Virginia Department of Health

Office of Emergency Medical Services

Quarterly Report to the

State EMS Advisory Board

February 7, 2020

Executive Management, Administration & Finance

Office of Emergency Medical Services
Report to The
State EMS Advisory Board

February 7, 2020

MISSION STATEMENT:

To reduce death and disability resulting from sudden or serious injury and illness in the Commonwealth through planning and development of a comprehensive, coordinated statewide emergency medical services (EMS) system; and provision of other technical assistance and support to enable the EMS community to provide the highest quality emergency medical care possible to those in need.

I. Executive Management, Administration & Finance

A) Action Items before the State EMS Advisory for February 7, 2020

At the time of finishing this report there are four (4) action items for the Board's consideration:

- The Training and Certification Committee moves to endorse changes to the TR-90A EMT Competency Tracking Requirements for Accredited EMT Programs in Virginia. Please see **Appendix D**.

- The Medical Direction Committee moves to endorse changes to the Virginia EMS Scope of Practice as follows: a) Clarification of EMT transport of a patient with IV fluids, b) Clarification of EMT administration of Epinephrine of Anaphylaxis, and c) addition of Hormones. Please see **Appendix E** for the motion and changes to the Scope of Practice Formulary Schedule.

- The Medical Direction Committee moves for the State EMS Advisory Board to *approve the MIH-CP White Paper* (Please see **Appendix F**)

- The Medical Direction Committee moves for the State EMS Advisory Board to *approve the MIH-CP Letter of Intent* (Please see **Appendix G**)

B) Proposed Emergency Medical Services Budget for FY2021 and FY2022

Item 296	First Year - FY2021	Second Year - FY2022
Emergency Medical Services (40200)	$46,180,757	$46,180,757
Financial Assistance for Non Profit Emergency Medical Services Organizations and Localities (40203)	$33,297,814	$33,297,814
State Office of Emergency Medical Services (40204)	$12,882,943	$12,882,943
Fund Sources:		
Special	$19,881,111	$19,881,111
Dedicated Special Revenue	$25,892,505	$25,892,505
Federal Trust	$407,141	$407,141

Authority: §§ 32.1-111.1 through 32.1-111.16, 32.1-116.1 through 32.1-116.3, and 46.2-694 A 13, Code of Virginia.

A. Out of this appropriation, $25,000 the first year and $25,000 the second year from special funds shall be provided to the Department of State Police for administration of criminal history record information for local volunteer fire and rescue squad personnel (pursuant to § 19.2-389 A 11, Code of Virginia).

B. Distributions made under § 46.2-694 A 13 b (iii), Code of Virginia, shall be made only to nonprofit emergency medical services organizations.

C. Out of this appropriation, $1,045,375 the first year and $1,045,375 the second year from the Virginia Rescue Squad Assistance Fund and $2,052,723 the first year and $2,052,723 the second year from the special emergency medical services fund shall be provided to the Department of State Police for aviation (med-flight) operations.

D. The State Health Commissioner shall review current funding provided to trauma centers to offset uncompensated care losses, report on feasible long-term financing mechanisms, and examine and identify potential funding sources on the federal, state and local level that may be available to Virginia's trauma centers to support the system's capacity to provide quality trauma services to Virginia citizens. As sources are identified, the commissioner shall work with any federal and state agencies and the Trauma System Oversight and Management Committee to assist in securing additional funding for the trauma system.

E. Notwithstanding any other provision of law or regulation, the Board of Health shall not modify the geographic or designated service areas of designated regional emergency medical services councils in effect on January 1, 2008, or make such modifications a criterion in approving or renewing applications for such designation or receiving and disbursing state funds.

F. Notwithstanding any other provision of law or regulation, funds from the $0.25 of the $4.25 for Life fee shall be provided for the payment of the initial basic level emergency medical services certification examination provided by the National Registry of Emergency Medical Technicians (NREMT). The Board of Health shall determine an allocation methodology upon recommendation by the State EMS Advisory Board to ensure that funds are available for the payment of initial NREMT testing and distributed to those individuals seeking certification as an Emergency Medical Services provider in the Commonwealth of Virginia.

G. Out of this appropriation, $90,000 the first year and $90,000 the second year from the Virginia Rescue Squad Assistance Fund shall be provided for national background checks on persons applying to serve as a licensed provider in a licensed emergency medical services agency. The Office of Emergency Medical Services may transfer funding to the Office of State Police for national background checks as necessary.

C) Item 303 – Financial Assistance to Community Human Services Organizations

Q. Out of this appropriation, $1,000,000 the first year and $1,000,000 the second year from the general fund shall be used to contract with three poison control centers. The State Health Commissioner shall review existing poison control services and determine how best to provide and enhance use of these services as a resource for patients with mental health disorders and for health care providers treating patients with poison-related suicide attempts, substance abuse, and adverse medication events. The Commissioner shall allocate the general fund amounts between the three centers. The general fund amounts shall be based on the proportion of Virginia's population served by each center.

D) § 3-1.01 INTERFUND TRANSFERS

W. On or before June 30 each year, the State Comptroller shall transfer $12,518,587 the first year and $12,518,587 the second year to the general fund from the $2.00 increase in the annual vehicle registration fee from the special emergency medical services fund contained in the Department of Health's Emergency Medical Services Program (40200).

E) § 3-6.02 ANNUAL VEHICLE REGISTRATION FEE ($4.25 FOR LIFE)

Notwithstanding § 46.2-694 paragraph 13 of the Code of Virginia, the additional fee that shall be charged and collected at the time of registration of each pickup or panel truck and each motor vehicle shall be $6.25.

F) § 3-6.03 DRIVERS LICENSE REINSTATEMENT FEE

A. Notwithstanding § 46.2-411 of the Code of Virginia, the drivers license reinstatement fee payable to the Trauma Center Fund shall be $100.

B. Notwithstanding the provisions of § 46.2-395 of the Code of Virginia, no court shall suspend any person's privilege to drive a motor vehicle solely for failure to pay any fines, court costs, forfeitures, restitution, or penalties assessed against such person. The Commissioner of the Department of Motor Vehicles shall reinstate a person's privilege to drive a motor vehicle that was suspended prior to July 1, 2019, solely pursuant to § 46.2-395 of the Code of Virginia and shall waive all fees relating to reinstating such person's driving privileges including those paid to the Trauma Center Fund. Nothing herein shall require the Commissioner to reinstate a person's driving privileges if such privileges have been otherwise lawfully suspended or revoked or if such person is otherwise ineligible for a driver's license.

G) Budget Amendments

1. **House amendment Item 296 #1h introduced by Delegate Chris Hurst states the following:**

   Emergency Medical Services Fund Transfer to the Trauma Center Fund (language only)

   Language

   Page 281, after line 50, insert:
   "H. The Virginia Department of Health shall transfer $12,518,587 the first year and $12,518,587 the second year from the special medical emergency services fund to the trauma center fund."

   Explanation

   (This amendment adds language directing the Department of Health to transfer $12.5 million each year from the Emergency Medical Services Fund to the Trauma Center Fund, providing a new funding source to offset the loss of driver's license reinstatement fee revenue due the state policy change of not suspending driver's licenses due to failure to pay fines, fees and court costs.)

2. **Senate amendment Item 296 #3s introduced by Senator Adam Ebbin states the following:**

Emergency Medical Services Fund Transfer to the Trauma Center Fund (language only)

Language

Page 281, after line 50, insert:
"H. The Virginia Department of Health shall transfer $12,518,587 the first year and $12,518,587 the second year from the special emergency medical services fund to the trauma center fund."

Explanation

(This amendment adds language directing the Department of Health to transfer $12.5 million each year from the Emergency Medical Services Fund to the Trauma Center Fund, providing a new funding source to offset the loss of driver's license reinstatement fee revenue due to the state policy change of not suspending driver's licenses due to failure to pay fines, fees and court costs.)

3. **Senate amendment Item 296 #3s introduced by Senator Emmett Hanger states the following:**

Transfer Funds from Emergency Medical Services Fund to the Trauma Center Fund (language only)

Language

Page 281, after line 50, insert:
"H. The Virginia Department of Health shall transfer $11,000,000 each year from the Special Emergency Medical Services fund to the Trauma Center Fund."

Explanation

(This amendment transfers $11 million each year from the Special Emergency Medical Services Fund to the Trauma Center Fund. A companion amendment in Part 3 eliminates a $12.5 million annual transfer from the Special Emergency Medical Services Fund to the general fund. This amendment redirects $11 million of that funding being transferred to the general fund to the Trauma Center Fund. This amendment provides a new funding source to offset the loss of revenue from the driver’s license reinstatement fee, which can no longer be collected in cases due to failure to pay fines or court costs. The remaining $1.5 million in funds would be left in the Special Emergency Medical Services Fund for distribution to emergency medical services providers as required by law.)

4. **Senate amendment Item 296 #2s introduced by Senator Jeremy McPike states the following:**

   Volunteer Background Checks

   Language

   Page 281, line 4, strike "$46,180,757" and insert "$46,280,757".
   Page 281, line 4, strike "$46,180,757" and insert "$46,280,757".
   Page 281, line 46, after "appropriation," strike "$90,000" and insert "$190,000".
   Page 281, line 46, after "first year and" strike "$90,000" and insert "$190,000".
   Page 281, line 48, after "serve as a" strike "licensed" and insert "certified or non-certified".

   Page 281, line 50, after "necessary." insert "The Virginia Department of Health shall continue to allow local EMS agencies to submit fingerprint cards for background checks on volunteers applying to be a member of local EMS agencies. The cost of the criminal background shall be paid from funds available to the Office of Emergency Medical Services."

   Explanation

   (This amendment clarifies policy that the cost of all criminal background checks for volunteers applying with local Emergency Medical Services (EMS) agencies is to be paid by the state Office of Emergency Services and that local EMS agencies may continue to submit fingerprint cards for processing as appropriate to reduce travel times for volunteers who otherwise may have to travel long distances to use the state's electronic scan vendor. The amendment provides $100,000 each year from the Rescue Squad Assistance Fund to assist in covering the costs.)

5. **House amendment Item 303 #1h introduced by Delegate Paul Krezek states the following:**

   Poison Control Centers

   Language

   Page 285, line 40, strike "$25,839,583" and insert "$29,339,583".
   Page 285, line 40, strike "$25,839,583" and insert "$29,339,583".
   Page 289, line 19, after "Q." insert "1."
   Page 289, line 19, strike "$1,000,000" and "$1,000,000" and insert: "$4,500,000"and "$4,500,000".
   Page 289, after line 26, insert:

"2. The State Health Commissioner, in consultation with the Department of Medical Assistance Services and the Department of Planning and Budget, shall study the feasibility of implementing a Children's Health Insurance Program Health Services Initiative to expand the services provided by the contracted poison control centers."

Explanation

(This amendment increases funding for three poison control centers and directs the State Health Commissioner, in consultation with the Department of Medical Assistance Services and the Department of Planning and Budget, to study the feasibility of implementing a Children's Health Insurance Program Health Services Initiative to expand the services provided by the contracted poison control centers.)

6. **Senate amendment Item 303 #1s introduced by Senator George Barker states the following:**

Poison Control Centers

Language

Page 285, line 40, strike "$25,839,583" and insert "$29,339,583".
Page 285, line 40, strike "$25,839,583" and insert "$29,339,583".
Page 289, line 19, after "Q." insert "1.".
Page 289, line 19, after "appropriation," strike "$1,000,000" and insert "$4,500,000".
Page 289, line 19, after "first year and" strike "$1,000,000" and insert "$4,500,000".
Page 289, after line 26, insert:

"2. The State Health Commissioner, in consultation with the Department of Medical Assistance Services and the Department of Planning and Budget, shall study the feasibility of implementing a Children's Health Insurance Program Health Services Initiative to expand the services provided by the contracted poison control centers."

Explanation

(This amendment increases funding for three poison control centers and directs the State Health Commissioner, in consultation with the Department of Medical Assistance Services and the Department of Planning and Budget, to study the feasibility of implementing a Children's Health Insurance Program Health Services Initiative to expand the services provided by the contracted poison control centers.)

7. **House amendment Item 296 #2h introduced by Delegate Marcia Price states the following:**

   Provide 500 AEDs to Community Organizations

   Language

   Page 281, line 4, strike "$46,180,757" and insert "$46,818,257".

   Explanation

   (This amendment provides $637,500 the first year from the general fund for the purchase of 500 Automated External Defibrillators (AEDs) to be given to organizations that consistently host events with 50 or more people on a regular basis. The AEDs would be distributed to the first 500 of such organizations that demonstrate a financial inability to purchase one on their own. These devices would help save lives in cases of heart incidents during their events.)

8. **House amendment Item 301 #1h introduced by Delegate Mark Sickles states the following:**

   Adult and Pediatric Traumatic Brain Injury Demonstration Project

   Language

   Page 284, line 12, strike "$170,087,860" and insert "$170,537,860".
   Page 284, line 12, strike "$170,087,860" and insert "$170,537,860".
   Page 285, after line 17, insert:

   "H. Out of this appropriation, $450,000 the first year and $450,000 the second year from the general fund shall be provided for the Virginia Department of Health to contract with an external party that can provide software to implement an adult and pediatric traumatic brain injury (TBI) pilot."

   Explanation

   (This amendment provides $450,000 each year from the general fund for the Virginia Department of Health to contract with an external party that can provide software to implement an adult and pediatric traumatic brain injury (TBI) pilot. The external party would provide the clinical decision support software tool to hospitals that have a trauma center and want to participate in the pilot program. The purpose of the pilot is to increase the participating hospitals' compliance with evidence-based treatment guidelines and best practices for severe adult and pediatric TBI in order to reduce patient mortality, improve patient level of recovery and reduce long-term care costs of the Commonwealth.)

9. **House amendment Item 301 #2s introduced by Senator George Barker states the following:**

Adult and Pediatric Traumatic Brain Injury Demonstration Project

Language

Page 284, line 12, strike "$170,087,860" and insert "$170,537,860".
Page 284, line 12, strike "$170,087,860" and insert "$170,537,860".
Page 285, after line 17, insert:

"H. Out of this appropriation, $450,000 the first year and $450,000 the second year from the general fund shall be provided for the Virginia Department of Health to contract with an external party that can provide software to implement an adult and pediatric traumatic brain injury (TBI) pilot."

Explanation

(This amendment provides $450,000 each year from the general fund for the Virginia Department of Health to contract with an external party that can provide software to implement an adult and pediatric traumatic brain injury (TBI) pilot. The external party would provide the clinical decision support software tool to hospitals that have a trauma center and would like to participate in the pilot program. The purpose of the pilot is to increase the participating hospitals' compliance with evidence-based treatment guidelines and best practices for severe adult and pediatric TBI in order to reduce patient mortality, improve patient level of recovery and reduce long-term care costs of the Commonwealth.)

NOTE: Legislation introduced in the 2020 Virginia General Assembly that directly or indirectly impacts EMS, and other bills of interest are distributed in a weekly OEMS Legislative Grid and Report every Friday during the 2020 session. You can also view these grids and reports on the OEMS web site.

H) Central Shenandoah EMS (CSEMS) Regional Office

Starting with this Quarterly Report to the State EMS Advisory Board, the Office of Emergency Medical Services will begin providing updates on the progress of the collaborative partnership(s) and the transition and conversion of applicable Regional EMS Councils that have requested to be a hybrid State/Regional EMS model. We begin with a summary of progress and status of the Central Shenandoah EMS Council/State Regional Office. Please see **Appendix A**

I) REPLICA (EMS Interstate Compact) Coordinated Database for Emergency Medical Services (CDEMS)

In Virginia, the REPLICA legislation was signed into law on March 1, 2016. This made Virginia the third state to enact the EMS Compact. Virginia Office of EMS Director, Gary Brown, was seated to the Interstate Commission for EMS Personnel Practice at the inaugural meeting on October 11, 2017. Activation of the EMS Compact required the legislation to be enacted by ten state legislatures. This occurred on May 8, 2017 with Georgia becoming the tenth state.

The Commission was tasked with producing the commission rules; which govern REPLICA activities amongst member states. Rules for the Interstate Commission for Emergency Medical Services (EMS) Personnel Practice became effective September 1, 2019. Essential to the EMS Compact is the Coordinated Database for Emergency Medical Services (CDEMS). This multi-state database will allow member states the ability to rapidly share EMS licensure records, discipline, and investigative information between authorized state EMS offices. In addition to licensure data, the database will maintain an individual's multi-state privilege to practice authorization. The National Registry of EMT's (NREMT) has partnered with the EMS Compact to create and maintain the database.

The Virginia Office of EMS is currently working with NREMT to implement the CDEMS database in Virginia. As such, ***Virginia will become the first state in the nation to "go live" with the CDEMS database and will serve as a guide to implementations in other member states.*** Nationwide "go live" of the CDEMS database is slated for mid-first quarter 2020.

J) Virginia collaborates with National Registry of EMTs (NREMT) for EMS Research

In 2004, the National Highway Traffic Safety Administration and the Maternal and Child Health Bureau published a national consensus document titled National EMS Research Agenda. One of the top recommendations from this document was:

"A large cadre of career EMS investigators should be developed and supported in the initial stages of their careers. Highly structured training programs with content directed toward EMS research methodologies should be developed."

Based upon this call, the National Registry of EMTs established a Research Department and founded the EMS Research Fellowship program to address the National Research Agenda's recommendation. The mission of the National Registry Research Department is to develop and

foster EMS-prepared doctoral researchers to function with the highest level of scientific integrity to improve and ensure high quality and innovative National Registry products and processes through evidence and collaboration. It is further the mission to contribute to the body of scientific out-of-hospital knowledge to improve the competency, health, safety and wellness of EMS professionals and the patients they serve.

Since its inception, the National Registry Research Department has conducted numerous studies focusing on the impact of burnout on the EMS workforce, prehospital EMS provider perceptions of errors and safety, factors predicting a negative perception of patient safety in the EMS workplace; just to name a few. Identifying the importance of these national research initiatives at a state level, the Office of EMS has partnered with the National Registry to have a dedicated doctoral fellow in the EMS Research Fellowship utilizing these national research initiatives specifically towards Virginia. Virginia will actively participate with the National Registry in the determination of future research initiatives and produce Virginia specific research results alongside national results. Further, the National Registry will provide periodic analysis to the Virginia Office of EMS, Virginia Department of Health and the Governor's EMS Advisory Board. Upon completion of a research topic, formal results will be provided to Virginia stakeholders at the EMS Advisory Board. For more information about the National Registry's completed research projects, visit www.nremt.org.

K) Community Based Emergency Response Seminar (CBERS)

The Virginia Department of Health's Office of Emergency Preparedness will conduct the Community Based Emergency Response Seminar (CBERS) this Spring throughout the Commonwealth. This year's topic is **Resilient Responder** ~ *Self-Care for Responders Before, During, & After an Emergency.*

- Target Audience: Any disaster or emergency responder

  - Emergency Management
  - Disaster Shelter Workers
  - EOC Staff
  - EMS/Fire/Law Enforcement
  - Emergency Dispatch
  - Emergency Department Staff
  - Local Health Districts and OCME Staff
  - Anyone who responds to emergencies or disasters as part of their job.

- Participants will learn about:

  - The effects of stress and trauma on human beings.
  - Strategies for resilience and your ability to bounce back.
  - How to develop a Personal Preparedness Plan (PPP).
  - How to activate your PPP if you find yourself in a stressful situation.
  - Various interventions related to disaster behavioral health.

- 3-Hour Workshop Dates & Locations

Richmond: April 8th	Fairfax: April 27th
Weyers Cave: April 15th	Stafford: April 28th
Abingdon: April 20th	Chesapeake: May 4th
Roanoke: April 21st	Newport News: May 5th

- Cost: Free-Everyone Must Register
- To Register: http://cbers2020.eventbrite.com.

- Partners:

  - Virginia Department of Behavioral Health & Developmental Services
  - Virginia Department of Social Services
  - Virginia Office of Emergency Medical Services
  - Virginia Department of Emergency Management
  - Virginia Hospital & Healthcare Association

For more information: Contact Adreania Tolliver at adreania.tolliver@vdh.virginia.gov or http://www.vdh.virginia.gov/emergency-preparedness/cbers-2020/

Please see **Appendix B** for Marketing Flyer

L) EMS Voluntary Event Notification Tool (E.V.E.N.T.)

E.V.E.N.T. is a program of the Center for Leadership, Innovation, and Research in EMS (CLIR) with sponsorship provided by the Savvik Foundation, the National EMS Management Association (NEMSMA), the Paramedic Chiefs of Canada (PCC), the National Association of Emergency Medical Technicians (NAEMT) and the National Association of State EMS Officials (NASEMSO).

E.V.E.N.T. is a tool designed to improve the safety, quality and consistent delivery of all Emergency Medical Services (EMS) by ground, air and water ambulance services operating in all delivery models. It collects data submitted anonymously by EMS practitioners. The data collected is used to develop policies, procedures and training programs to improve the safe delivery of EMS. A similar system used by airline pilots has led to important airline system improvements based upon pilot reported "near miss" situations and errors.

Any individual who encounters or recognizes a situation in which an EMS safety event occurred, or could have occurred, is strongly encouraged to submit a report by completing the appropriate E.V.E.N.T. Notification Tool (see below). The confidentiality and anonymity of this reporting tool is designed to encourage EMS practitioners to readily report EMS safety events without fear of repercussion.

All reported patient safety events and aggregate reports are posted to an EVENT Google Group. If you would like to be added to the Google Group, send an email to clirems@gmail.com with your name and EMS agency or affiliation. You will be added to the group within 2 business days.

- PATIENT SAFETY EVENT (PSE) REPORT

Any individual who encounters or recognizes a situation in which a patient safety event occurred, or could have occurred, while a patient was being cared for by the EMS system is strongly encouraged to submit a report by completing the Patient Safety E.V.E.N.T. Notification Tool. The confidentiality and anonymity of this reporting system is designed to encourage EMS and other providers to readily report EMS patient safety events without fear of repercussion.

EVENT defines a patient safety event as any event or action that leads to or has the potential to lead to a worsened patient outcome related to the event or action: these may be related to systems, operations, drug administration or any clinical aspect of patient care. Patient safety events also include patient Near Misses (i.e. close calls) that are recognized before they actually occur.

This notification system is anonymous. Individuals who submit information to this website cannot be identified. Individuals must not submit information that identifies any patient, EMS practitioner, EMS service, air medical service, date of incident, location of incident, or any other information that may identify any of these entities. Submissions with these identifiers will be deleted from the system and the report will not serve the purpose of reducing future events.

Aviation accidents and incidents that involve precautionary landings or aircraft damage to medical helicopters or airplanes should be reported through the CONCERN Network at: http://www.concern-network.org/

- PROVIDER VIOLENCE EVENT REPORT

Violence Against EMS Provider Reporting Tool. The Violence against EMS Provider Reporting Tool is developed by the Center for Leadership, Innovation and Research in EMS in cooperation with the National EMS Management Association (NEMSMA). This tool has been created for EMS practitioners to anonymously share violence against EMS provider information by answering a series of questions in an online format. The data collected will be analyzed and possibly used in the development of EMS policies and procedures, as well as for training, educating and preventing similar events from occurring in the future.

- PRACTITIONER NEAR MISS EVENT REPORT

The EMS Near Miss Event reporting tool is developed by the Center for Leadership, Innovation and Research in EMS in cooperation with the National Association of Emergency Medical Technicians (NAEMT). This tool has been created for EMS practitioners to anonymously share near-miss information by answering a series of questions in an online format. The data collected will be analyzed and possibly used in the development of EMS policies and procedures, as well as for training, educating and preventing similar events from occurring in the future.

EMS Near Miss Event: An unplanned event that did not result in injury, illness, or damage to an EMS practitioner, vehicle, aircraft, or equipment, but had the potential to do so. Only a fortunate break in the chain of events prevented an injury, fatality or damage. A near miss event that is patient related should be reported as a "Patient Safety Event".

EMS Event Resulting in Illness, Injury or Damage: This tool is NOT designed to collect events involving illness, injury or damage. Those events should be reported to your EMS agency as directed by your agency policy.

- How to Report

To make an anonymous report on an EMS incident to E.V.E.N.T., please click one of the following links below:

Near MissEvent: http://event.clirems.org/Near-Miss-Event

Patient Safety Event: http://event.clirems.org/Patient-Safety-Event

Violence Event: http://event.clirems.org/Provider-Violence-Event

M) Financial Assistance for Emergency Medical Services (FAEMS) Grant Program, known as the Rescue Squad Assistance Fund (RSAF)

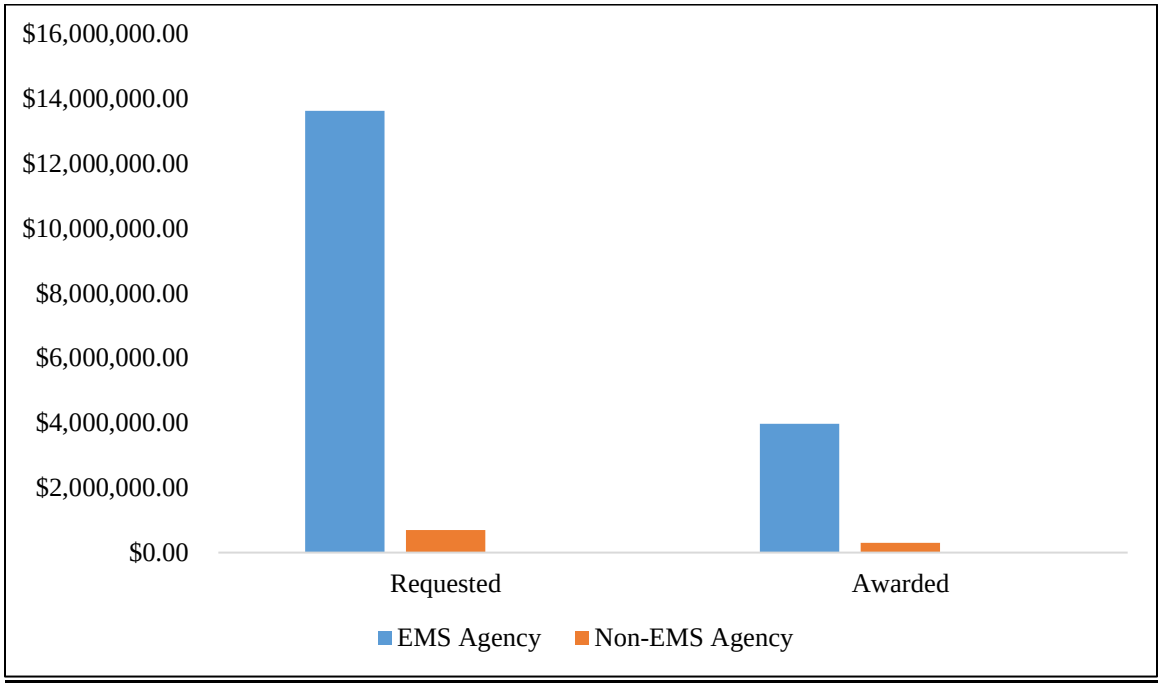
Luke Parker, Grants Manager
Linwood Pulling, Grants Specialist

The deadline for the Fall Rescue Squad Assistance Fund (RSAF) Grant Cycle was September 16, 2019. OEMS received grant applications from 112 agencies requesting $14,322,703.98 in funding. OEMS awarded 70 agencies a total of $4,273,912.46.

Awarded agencies fall into the following categories:

- 65 EMS Agencies awarded $3,976,183.10
- 5 Non-EMS Agencies awarded $297,729.36

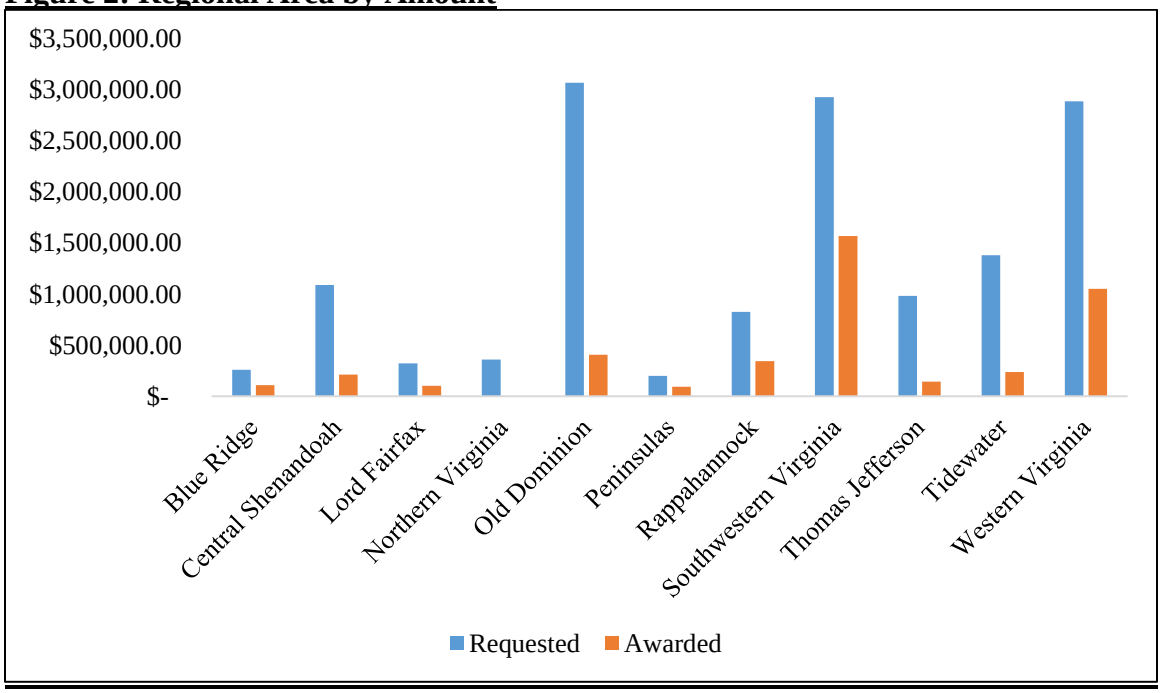
Figure 1: Agency Category by Amount



Award totals by EMS Region are as follows:

- Blue Ridge – $108,190.88
- Central Shenandoah - $212,278.25
- Lord Fairfax - $104,116.34
- Northern Virginia - $0.00
- Old Dominion - $406,021.85
- Peninsulas - $91,884.28
- Rappahannock - $343,730.86
- Southwestern Virginia - $1,570,302.31
- Thomas Jefferson - $144,932.51
- Tidewater - $238,453.96
- Western Virginia - $1,054,001.22

Figure 2: Regional Area by Amount

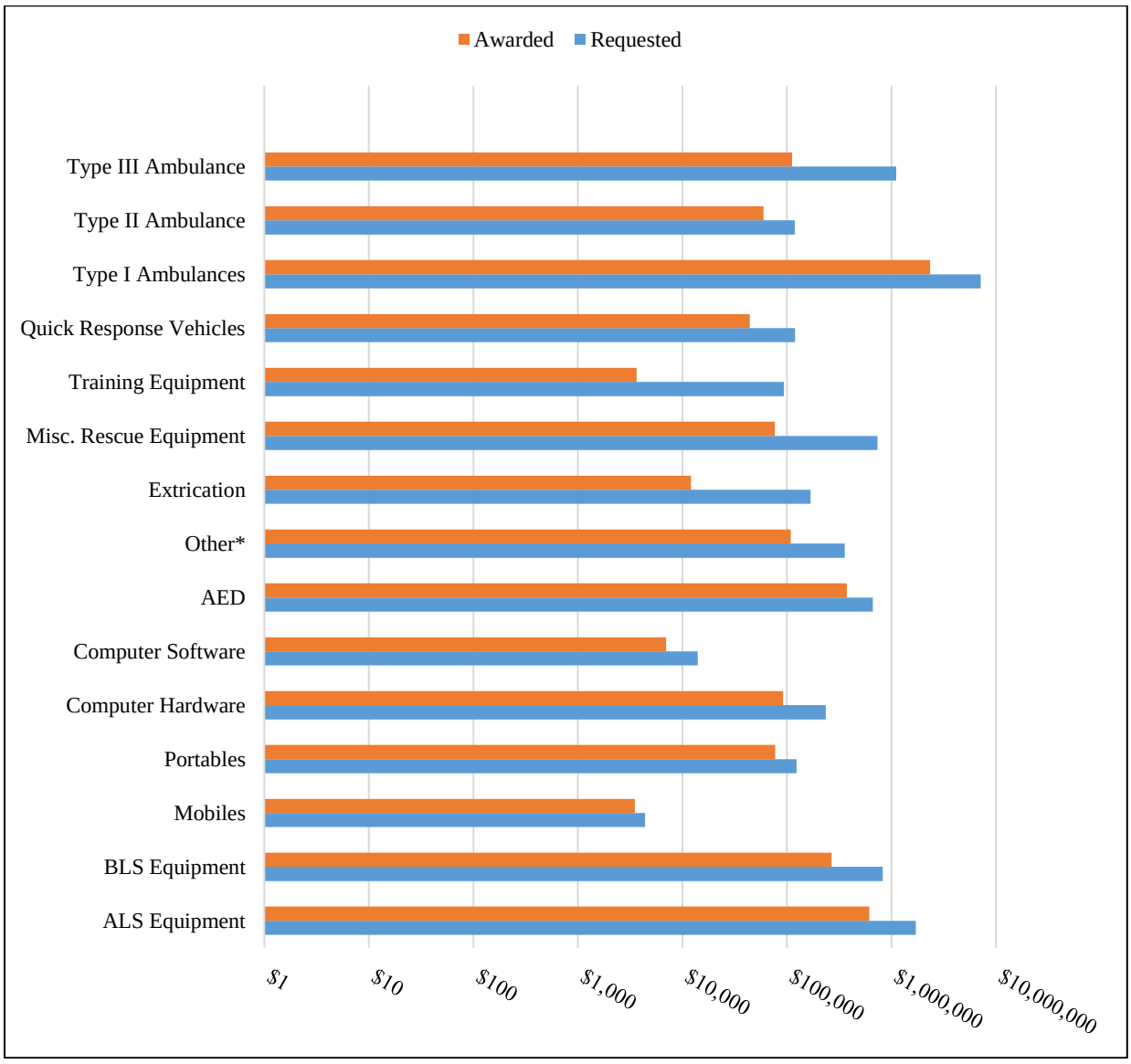


Award totals by equipment category are as follows:

- ALS Equipment: $614,303.37
- BLS Equipment: $267,211.50
- Communications Equipment – Mobiles: $3,507.74
- Communications Equipment – Portables: $77,373.00
- Computer Hardware: $92,037.07
- Computer Software: $7,006.53
- Defibrillator - Automatic External Defibrillator: $374,550.47
- Other*: $108,918.96
- Rescue Equipment – Extrication: $12,114.00
- Rescue Equipment - Misc.: $76,948.33
- Special Priority - Emergency Medical Dispatch: $70,304.52
- Training Equipment - ALS / BLS: $3,639.97
- Vehicle - Quick Response Vehicle: $44,000.00
- Vehicle - Type I Ambulance: $2,349,831.20
- Vehicle - Type II Ambulance: $59,621.00
- Vehicle - Type III Ambulance: $112,544.80

*The "Other" Category includes stretchers, load systems, and cot retention systems that applicants categorized as "other" in their application.

Figure 3: Item by Amount



The awards meeting for the Fall Cycle of RSAF was held on December 5, 2019 in Richmond, Virginia. The Financial Assistance Review Committee (FARC) recommended the above grant projects to the Health Commissioner for final approval. OEMS released award notifications on January 1, 2020. The application period for the Spring Cycle of RSAF opened on January 31, and will close March 16, 2020.

Nasal Naloxone for EMS Agencies (NNEA) Spring 2020 Grant Cycle –

The State Health Commissioner declared the National Opioid Crisis a Virginia public health emergency in 2016. Virginia's Office of Emergency Medical Services (OEMS) created the Nasal Naloxone for EMS Agencies (NNEA) in-kind grant program to address the public health emergency by providing licensed EMS agencies with access to Naloxone - medication that can reverse the effects of opioid overdose.

The goal of NNEA is to prevent drug overdose deaths involving opioids in Virginia by consistently providing no cost Nasal Naloxone to licensed EMS agencies while the Declaration is in effect. Licensed EMS agencies pursuant to § 32.1-111.12 of the Code of Virginia may apply for NNEA through the EMS-Grant Information Funding Tool (E-GIFT).

The NNEA application requires verification of applicants' nonprofit status, federal identification number (FIN), and electronic signatures from the Authorized Agent, Financial Officer, and Operational Medical Director (OMD).

Additionally, applicants must provide a valid shipping address to receive the medication. The Spring Cycle of NNEA opened for applications on January 27 and will close on June 30, 2020. The full announcement for the Spring 2020 NNEA Cycle is included in **Appendix C.**

EMS on the National Scene

II. EMS On the National Scene

National Association of State EMS Officials (NASEMSO)

Note: The Virginia Office of EMS is an active participant in the NASEMSO and has leadership roles on the Board of Directors and in each NASEMSO Council. The National Association of State EMS Officials is the lead national organization for EMS, a respected voice for national EMS policy with comprehensive concern and commitment for the development of effective, integrated, community-based, universal and consistent EMS systems. Its members are the leaders of their state and territory EMS systems.

A. Specialized Systems of Care Highlighted on Committee Microsite

The Specialized Systems of Care Committee has begun populating its web site with resources on systems of care for time sensitive emergencies where quantifiable evidence is already available, such as STEMI and stroke. The committee is currently collecting data to benchmark activities in the states with results anticipated in the spring 2020. For more information on how to join the committee roster, please contact NASEMSO Program Manager, Kathy Robinson.

B. Taillac Launches New Column for EMSWorld

Starting this month, EMSWorld launches a new feature authored by the nation's top EMS physicians and medical directors titled "Resident Eagle." In the January 2020 issue of EMSWorld, Dr. Peter Taillac, a prominent NASEMSO member and Utah's state EMS medical director, highlights the new evidence based guideline on the administration of naloxone for EMS. To read the article go to: https://www.emsworld.com/article/1223677/resident-eagle-naloxone-guidance-ems.

C. Creating and Using Evidence-based Quality Measures in EMS: The National EMS Quality Alliance

A collaboration of several national EMS organizations, the National EMS Quality Alliance (NEMSQA) recently released its first set of measures after a robust and rigorous process. These national measures, which use data elements from the National EMS Information System (NEMSIS), will help EMS agencies across the country measure and benchmark their performance in key operational and clinical areas and improve the effectiveness of the care provided to patients and communities. In an upcoming EMS Focus webinar, hosted by the NHTSA office of EMS, you'll hear from leaders of NEMSQA who were involved in the development, testing, and implementation of these

EMS performance measures. You can read more and register here: https://www.ems.gov/ems-focus.html.

D. Nurse Program Cuts Non-emergent Ambulance Dispatches in Florida

The Daytona Beach News-Journal is reporting that a nurse-led program implemented in Volusia County, Fla., is helping redirect 911 calls for non-emergency situations and reduce ambulance dispatches. The program is staffed with seven part-time nurses from Halifax Health and AdventHealth in addition to one full time-nurse. They have all been trained as 911 operators and work in the same room as the full-time county 911 operators. The program, which started Dec. 9 and runs from 7 a.m. to 7 p.m. Monday through Friday, diverted 20% of 911 calls in its first week. Similar programs exist in Reno, Las Vegas, and Fort Worth. Read more at: https://www.news-journalonline.com/news/20191226/nurse-program-helps-lower-emergency-dispatches-in-volusia.

E. Air Medical - DOT Announces Proposed Rule on Remote ID for Drones

The U.S. Department of Transportation's Federal Aviation Administration (FAA) has announced a proposed rule. To read the rule, please go to: https://www.federalregister.gov/documents/2019/12/31/2019-28100/remote-identification-of-unmanned-aircraft-systems. The proposed rule would continue the safe integration of Unmanned Aircraft Systems (UAS), commonly called drones, into the nation's airspace by requiring them to be identifiable remotely. The proposed Remote ID rule would apply to all drones that are required to register with the FAA (recreational drones weighing under 0.55 pounds are not required to register), as well as to persons operating foreign civil UAS in the U.S.

F. Communications

- **GIS Data Requirements for NG911**

Next Generation 911 (NG911) is deploying nationwide and it brings big changes to emergency dispatch and response. One of the biggest changes involves geographic information systems (GIS). NG911 is much more data-rich and will have the benefit of improved call routing thanks to GIS data. Location information will be more complete allowing dispatchers to direct responders to the correct location. The National Emergency Numbers Association (NENA) developed the Standard for the NG911 GIS Data Model, defining the structure of GIS data necessary for NG911. This is a very technical document defining the terminology, definitions, keywords and structure of the GIS data model layers. 911 leadership should work with GIS professionals to ensure location layers and GIS data fields meet the needs of NG911

- **Next "State of 911 Webinar Series" to Focus on NG911 Self-Assessment Tool**

NHTSA's National 911 Program offers a series of webinars to educate first responders and the public on matters related to the 9-1-1 system. Several of the webinars have featured EMS-related topics, such as CPR Life Links, caller location, and more. The next webinar in the series will highlight the NG911 Self-Assessment tool. All webinars are recorded and available at: https://www.911.gov/webinars.html.

The NG911 Self-Assessment tool was distributed by NHTSA last summer. Go here to view the tool: https://www.911.gov/project_ng911tool.html.

G. Health & Medical Preparedness

- **DSCSA Unit of Measure Requirements Now in Effect**

The Drug Supply Chain Security Act (DSCSA) outlines requirements for manufacturers, repackagers, wholesale distributors, dispensers, and third-party logistics providers (trading partners). The impact of this regulation is starting to be felt in EMS markets as customers are no longer able to buy individual units of use such as vials or bottles as manufacturers work to comply with the law regarding product traceability through serialization. The deadline, which became effective November 27, 2019, requires pharmaceutical products subject to DSCSA to be affixed with a product identifier at every unit of sale. To read more go to: https://www.fda.gov/drugs/drug-supply-chain-integrity/drug-supply-chain-security-act-dscsa.

- **TRACED Act Expected to Reduce Tech Threats Caused by Robocalls**

Last month, the U.S. House of Representatives and Senate each passed the TRACED (Telephone Robocall Abuse Criminal Enforcement and Deterrence) Act. The Bill has now been signed by the President into law. It gives the Federal Communications Commission (FCC) greater enforcement authority against illegal robocallers, and requires voice service providers to implement call authentication technology. As part of a Federal Communications Commission push, major wireless carriers and home phone providers have been implementing a verification process known as STIR/SHAKEN throughout 2019 to authenticate calls and fight spammers. In addition to raising penalties and pushing for authentication, the bill also gives regulators like the FCC and the Federal Trade Commission (FTC) four years to go after scammers, as opposed to the one-year statute of limitations that was previously in place.

- **ASPR/TRACIE Resources Highlighted**

The link below is for resources that highlight lessons learned from recent events, communication tools and information, and checklists, plans, tools, and templates that can be modified to suit specific threats and needs. Articles address specific natural disasters

and hazards and elements of their planning, but do not address all-hazard planning or specifics of clinical care which may be found in other topic collections. For more information go to: http://%20https//asprtracie.hhs.gov/technical-resources/36/Natural-Disasters/0.

H. Highway Incident & Transportation Systems

- **FHWA's New Transportation Performance Measures Website**

The Federal Highway Administration has re-organized its TPM website to make it easier to find the latest Transportation Performance Management (TPM) information. Performance and target data from all 52 States for 17 national measures are available in one place at: https://www.fhwa.dot.gov/tpm/reporting/state/.

This data is also available as a downloadable ZIP file. The Highway Safety related measures can be accessed by clicking on your state.

- **Autonomous Car Tester Offers Guide for Firefighters**

Google spinoff Waymo is trying to educate emergency responders on how to deal with its autonomous vehicles. Waymo released a training video on YouTube Thursday geared toward guiding public safety officials responding to incidents involving their self-driving cars. The 14-minute instructional video advises how to put a car in manual mode and what precautions firefighters should take. The video was done in conjunction with Waymo engineers and suburban Phoenix police and firefighters. For more information go to: https://www.fireengineering.com/2019/11/23/481423/autonomous-car-tester-offers-guide-for-first-responders/#gref.

- **Updated: 2019-2020 NTSB Most Wanted List**

The "MOST WANTED LIST," the National Transportation Safety Board's premier advocacy tool, identifies the top safety improvements that can be made across all modes to prevent accidents, minimize injuries, and save lives in the future. These issue areas are ripe for action now; if addressed, they would make a significant impact. The MOST WANTED LIST is the NTSB's road map from lessons learned to lives saved. Go to: https://www.ntsb.gov/safety/mwl/Pages/default.aspx

- **NTSB Expands Medical Fitness Recommendations to include OSA Screening**

The National Transportation Safety Board (NTSB) has expanded its medical fitness recommendations to include screening and treating for obstructive sleep apnea (OSA.) Undiagnosed and untreated obstructive sleep apnea (OSA)—and the fatigue that results from it— continues to be deadly on our highways. OSA is a treatable chronic disease in which patients experience episodes of airway obstruction while sleeping, resulting in

fragmented sleep and subsequent daytime sleepiness and fatigue. OSA often goes undiagnosed in the transportation environment, which increases the risk that drivers will suffer from fatigue and perform their duties in an unsafe manner. Highway personnel in safety-sensitive positions need to be screened for OSA and treated if necessary. Among commercial drivers, when treated, OSA is not a medically disqualifying condition for transportation operators in safety-sensitive positions.

In related news, through its ongoing work with the National Highway Traffic Safety Administration (NHTSA) and the University of Pittsburgh, NASEMSO supported the publication of a special supplement in Prehospital Emergency Care aimed at EMS fatigue. Direct links to 15 manuscripts can be found on NASEMSO's project website at: https://nasemso.org/projects/fatigue-in-ems/.

I. Pediatrics

- **Focused Updates on PALS Highlighted in Current Issue of Pediatrics**

The January issue of Pediatrics, the official journal of the American Academy of Pediatrics, features three focused updates to the 2019 American Heart Association Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care. View the Table of Contents to access these updates at: https://pediatrics.aappublications.org/content/145/1?current-issue=y.

- **AAP Joins Organizations in Pediatric Readiness Position Statement**

The American Academy of Pediatrics (AAP) has published a joint policy statement with the American College of Emergency Physicians, Emergency Nurses Association, National Association of Emergency Medical Services Physicians, and National Association of Emergency Medical Technicians on pediatric readiness in emergency medical services systems that is now available online.

- **AJCC Offers Overview of Changes to Severe TBI Guidelines in Pediatrics**

In their January issue, the American Journal of Critical Care (AJCC) offers a (free) summary of the recent update of the "Third Edition of the Guidelines for Managing Severe Traumatic Brain Injury in Children." These highlights can help critical care providers apply the most current and appropriate therapies for children with severe TBI. The key criteria for inclusion in the guidelines were (1) the study population included pediatric patients (≤ 18 years) with severe TBI (score of 3-8 on the Glasgow Coma Scale [GCS]) and (2) the study assessed for and included outcome data such as neurologic function, mortality, or appropriate intermediate targeted topic outcomes. Go to: https://aacnjournals.org/ajcconline/article/29/1/e13/30622/Critical-Update-on-the-Third-Edition-of-the.

- **New ED Toolkit to Support Children in Mental Health Crisis**

The Health Resources Services Administration (HRSA) recently released a new toolkit: Critical Crossroads. This resource was created to help hospital emergency departments better manage and coordinate care for children and adolescents in mental health crisis. This resource is targeted to all hospitals, but rural hospitals have been specifically included as a key audience for this resource from its inception, and the guide includes examples from a few rural hospitals on what they've put into place within their EDs. The resources can be tailored to your specific needs, patient population, and community. Download the toolkit here and listen to the webcast to learn why the toolkit was developed and how to use it: https://www.hrsa.gov/sites/default/files/hrsa/critical-crossroads/critical-crossroads-tool.pdf.

Division of Accreditation, Certification and Education (ACE)

III. Accreditation, Certification and Educations (ACE)

Committees

A. The Training and Certification Committee (TCC): The Training and Certification Committee met on January 15, 2020. There is one action item for the Board. The Training and Certification Committee moves to endorse changes to the TR-90A EMT Competency Tracking Requirements for Accredited EMT Programs in Virginia. Please see **Appendix D** for the motion and TR-90A document.

Copies of past minutes are available on the Office of EMS Web page here: http://www.vdh.virginia.gov/emergency-medical-services/education-certification/training-certification-committee-standing/.

B. The Medical Direction Committee (MDC): The Medical Direction Committee met on January 16, 2020. There is one action item for the Board. The Medical Direction Committee moves to endorse changes to the Virginia EMS Scope of Practice as follows: a) Clarification of EMT transport of a patient with IV fluids, b) Clarification of EMT administration of Epinephrine of Anaphylaxis, and c) addition of Hormones. Please see **Appendix E** for the motion and changes to the Scope of Practice Formulary Schedule.

Copies of past minutes are available from the Office of EMS web page at: http://www.vdh.virginia.gov/emergency-medical-services/education-certification/medical-direction-committee-standing/

Accreditation

A. EMS accreditation program.

1. Emergency Medical Technician (EMT)

a) Arlington County Fire Department continues under Letter of Review pending their accreditation site visit.

b) Fauquier County is under a Letter of Review and their first cohort class has occurred. They will remain under Letter of Review pending their accreditation visit.

c) Hampton Roads Regional EMS Academy has submitted documentation for accreditation. Their Letter of Review has been issued to allow their first cohort to occur.

d) Augusta County is under Letter of Review to allow their first cohort to occur.

e) Rockingham County Dept. of Fire and Rescue has submitted documentation for accreditation. Their Letter of Review will be issued after submission of final documentation is received.

f) Gloucester Volunteer Fire and Rescue is under Letter of Review to allow their first cohort to occur.

2. EMT Psychomotor Competency Verification Approval

The interest in BLS accreditation continues to grow. We currently have 18 programs that are approved for internal psychomotor competency verification in adherence to the TR-90A policy. Five programs are still approved under the original BLS accreditation process and the Office will be working with them to move them to convert them to psychomotor exempt programs as well.

3. Advanced Emergency Medical Technician (AEMT)

a) All Intermediate-99 programs have been moved to the AEMT level of accreditation and expiration dates extended until December 31, 2021 to allow the office to send reaccreditation documentation to all programs and site visits can be scheduled.

b) Newport News Fire Training has completed their first cohort class and a site team is being assigned to visit the program and review documentation, meet with graduates of the program and consider the application for full accreditation. They had 17 candidates attempt with a first attempt pass rate of 94% (16/17) and 100% within three attempts.

c) Fauquier County has completed their first cohort class and a site team is being assigned to visit the program and review documentation, meet with graduates of the program and consider the application for full accreditation. They had 6 candidates attempt with a first attempt pass rate of 83% (5/6).

d) Rockbridge County is has been issued their Letter of Review to conduct their first cohort class.

e) Hampton Roads Regional EMS Academy is under Letter of Review. Their first cohort class has completed and is in the testing process.

4. Paramedic – Initial

a) Blue Ridge Community College has been issued their LOR from CoAEMSP and is enrolling students for their first cohort class.

b) Thomas Nelson Community College has completed their first cohort class and are their CoAEMSP site visit is being scheduled.

c) Henrico County Division of Fire has been issued a LOR from CoAEMSP and will be enrolling students for their first cohort class.

5. Paramedic – Reaccreditation

a) None at this time.

B. For more detailed information, please view the Accredited Site Directory found on the OEMS web site at:
https://vdhems.vdh.virginia.gov/emsapps/f?p=200:1

Certification

1. The 2020 National Registry recertification cycle opened on October 1, 2019. As in the previous two years, the Division of Accreditation Certification and Education has developed a Quick Guide to assist all certified providers in Virginia who maintain their National Registry certification with an abbreviated process to completing the recertification application. The quick guide is available on the OEMS webpage at the following link: http://www.vdh.virginia.gov/content/uploads/sites/23/2019/10/Quick-Guide-Completing-National-Registry-Recertification-Application-2019.pdf.

2. The Office of EMS has authorized early access which allows Virginia Program Directors, in coordination with the program Medical Director to allow ALS testing candidate's access to the psychomotor examination at the point in their program they feel the students have reached competency. Information has been provided to all program directors.

3. Virginia certified providers can complete all continuing education requirements through online distributive education. This will satisfy not only their Virginia recertification requirements but will also be accepted by National Registry due to Virginia having oversight of all online education approved. The link to identify approved online distributive education is: http://www.vdh.virginia.gov/emergency-medical-services/education-certification/provider-resources/web-based-continuing-education/.

National Registry

National Registry Announces Policy Changes:

Under 18 Testing Candidates Will Now Take Certification Exam – Not Assessment Exam

Effective October 1, 2019, National Registry remove the age requirement for taking the National Registry cognitive examination. All students, regardless of age, will now register to take the

National Registry EMT cognitive examination, selecting their Education Coordinator teaching the class as their Program Director.

Virginia Education Coordinators will be able to approve their application for course completion and track their progress through the testing process.

National Registry is removing all existing assessment examination applications in their system for current students. Any student who had completed an assessment examination application will need to submit the certification application.

Test Scores to Remain Valid for Two Years:

Passing scores on cognitive and psychomotor examinations can be applied to applications for initial certification for up to 24 months (two years) from the date of successful examination, so long as all other requirements for eligibility are met and it falls within 24 months of course completion.

"The 24-month time period for which examinations are valid provides consistency as it relates to other National Registry policies," said Bill Seifarth, Executive Director of the National Registry of EMTs. "Bringing everything in line to a 24-month standard reduces confusion and means less guesswork as to which timeframe applies to what policy, standard or certification."

This policy is a change from the previous policy where results for initial certification were valid for up to 12 months.

This policy will become effective for candidates with a course completion date of November 2018 or later. The prior 12-month time period for valid examination results applies to courses that end before November 2018, extending the time period after November 2019.

The policy can be found here: https://zurl.co/fS8P

Testing fees increase in 2021

The National Registry recently finalized the 2021 initial certification fee schedule. It will be announced publicly later this year but has been shared with state officials.

Beginning January 1, 2021, initial certification fee will be as follows:

NREMT Level	Current Fee	Effective 1/21/2021
EMR	$75	$85
EMT	$80	$98
AEMT	$115	$136
Paramedic	$125	$152

More information will be shared when the announcement is released to the broader public.

Education Program

A. Education Coordinators (EC)

1. The New Education Coordinator process continues to be successful. As of October 17, 2019, there are 23 EC Applicants and 230 EC Candidates.
2. The Division is returning to its previous practice of holding three (3) Education Coordinator Institutes per year. More information can be found at: http://www.vdh.virginia.gov/emergency-medical-services/ems-education-coordinator-requirements/
3. EMS Providers interested in becoming an Education Coordinator can access reference documents on the website at http://www.vdh.virginia.gov/emergency-medical-services/ems-education-coordinator-requirements/. Additionally, providers can contact Chad Blosser at chad.blosser@vdh.virginia.gov or call the office at 804-888-9124.
4. The EC recertification process is paperless. EMS Physicians now directly click recommendation for recertification in their portal. When an EC selects their EMS Physician, it will automatically generate an email overnight to the physician alerting them of the action needed in their portal.

B. EMS Educator Updates:

The Office has held one EC update since the November Board meeting—in the PEMS Region. The schedule of updates for 2020 can be found on the OEMS web at: http://www.vdh.virginia.gov/emergency-medical-services/ems-educator-update-schedule/. The Office would like to thank all of those who have graciously offered their facilities to host the updates as we travel across the state. Educators are encouraged to attend updates more frequently than once in a three year period as valuable information is shared during these meetings.

C. ALS Coordinator Updates:

1. ALS Coordinator re-endorsement requires an update every two years and the submission of a re-endorsement application. An EMS Physician must sign the application. Additionally, it must contain the signature of the regional EMS council director if courses are being conducted in their region.

EMS Training Funds

Table. 1 – Virginia EMS Scholarship Program – FY20 (Q1 & Q2)		
Certification Level	**No. Awarded**	**Amount Awarded**
EMR	--	--
EMT	175	$105,693.00
AEMT	2	$2,424,00
Paramedic	176	$630,313.00
Grand Total	**353**	**$738,430.00**

Psychomotor Test Site Activity

A. With the retirement of Warren Short and Peter Brown, the Consolidated Testing process has moved back to the Division of Accreditation, Certification and Education. All CTS Supervisors are reporting to Debbie Akers.

B. The psychomotor examination workgroup held their first meeting in December, 2019 to review the psychomotor testing process for non-accredited BLS programs. The committee is currently working on changes to the testing process that will allow the evaluation of EMT students using critical thinking rather than rote memorization of check sheets.

Other Activities

- Debbie Akers is serving on the committee to rewrite the Education Standards and Instructional Guidelines. The first draft of the proposed Education Standards has been released and a stakeholders meeting was held on October 3, 2019 in Washington, DC. The committee is now taking the comments received during the public comment phase and at the stakeholders meeting to make revisions. The second draft will be released in spring 2020 with an anticipated effective date of August, 2020.

Community Health and Technical Resources (CHaTR)

IV. Planning and Regional Coordination

CHaTR Website

The CHaTR division has its own section on the Virginia OEMS website at the link below:

http://www.vdh.virginia.gov/emergency-medical-services/chatr/

Regional EMS Councils

The OEMS continues to maintain a Memorandum of Understanding (MOU) with the Regional EMS Councils for the 2019 Fiscal Year. The Regional Councils are submitting their FY19 Second Quarter reports throughout the month of January, and are under review. OEMS has transitioned to a web based reporting application to replace Lotus Notes for the Regional EMS Councils to submit quarterly deliverables.

The OEMS, Dr. Jaberi and the Regional Council Executive Directors met on December 6, 2019 to discuss various aspects of the regional council programs including a planning session to evaluate the current MOUs in place and any possible modifications to future MOUs. A future meeting to continue dialog is being coordinated in the spring of 2020.

CHaTR staff attended various Regional Council meetings including; five Board of Director meetings, one performance improvement committee meeting, and one newly established committee promoting planning and collaboration in the region.

The Blue Ridge and Rappahannock EMS Councils have also entered into MOU agreements to transition into OEMS Regional Offices. OEMS staff is working with the Board of Directors of those respective councils for implementation throughout 2020.

Medevac Program

The medevac program is in the process of transition from the CHaTR division to the Trauma/Critical Care division. This process will be completed in 2020.

The Medevac Committee is scheduled to meet on February 6, 2020. The minutes of the December 18, 2019 meeting are available on the OEMS website linked below:
http://www.vdh.virginia.gov/emergency-medical-services/advisory-board-committees/medevac-committee/

The amount of data submitted to the Medevac Helicopter EMS application (formerly known as WeatherSafe) continues to grow. In terms of weather turndowns, there were 480 entries into the Helicopter EMS system in Q4 of the 2019 calendar year. 63% of those entries (304 entries) were for interfacility transports, which is consistent with information from previous quarters. The total number of turndowns is a decrease from 591 entries in Q4 of 2018. For the 2019 calendar year, there were 2,081 entries into the system. 60% of those entries (1,260 entries) were for interfacility transports, which is consistent with previous information. The total number of turndowns is a decrease from 2,782 entries in the 2018 calendar year. This data continues to demonstrate a commitment to the program and to maintaining the safety of medevac personnel and equipment.

The Committee continues to evaluate the increased use of unmanned aircraft (drones), and the increased presence in the airspace of Virginia. A workgroup continues work to raise awareness among landing zone (LZ) commanders and helipad security personnel.

The Office of EMS has developed a form intended for a health care provider to notify a patient or his/her authorized representative that the health care provider is requesting air medical transport for the patient who may not have an emergency medical condition.

The form can be found via the link below:
http://www.vdh.virginia.gov/content/uploads/sites/23/2019/03/Air-Medical-Transport-Authorization-Form.pdf

The CHaTR division manager participates on the NASEMSO Air Medical Committee. OEMS and Medevac stakeholders continue to monitor many developments regarding federal legislation and other documents related to Medevac safety, regulation, and the cost of providing air medical services.

State EMS Plan

The Virginia Office of EMS Strategic and Operational Plan is mandated through *The Code of Virginia* to be reviewed and revised on a triennial basis.

The final draft of the most recent version of the State EMS Plan was approved by the Governor's Advisory Board, at the November 6, 2016 meeting. The Plan was presented to the Board of Health, and unanimously approved at their March 16, 2017 meeting.

Review and revision of the State EMS Plan began in early 2019. Committee chairs, OEMS staff, and Regional EMS Council staff have received the current 2016-2019 plan and the guidance documents for the triennial review and revision period. Reports from committees for edits, additions and deletions have been compiled into a draft of the 2020 State EMS Plan. On October 16, 2019, the Legislative and Planning Committee met during a special called planning session. During this meeting the committee reviewed and

made final edits to the plan and subsequently voted unanimously to approve the draft 2020-2022 State EMS Plan.

The State EMS Plan was unanimously approved by the state EMS Advisory Board at their meeting on November 6, 2019. The Board of Health will be requested to adopt the plan at their March 26, 2020 meeting.

The current version (2016-2019) of the State EMS Plan is available for download via the OEMS website at the link below:
http://www.vdh.virginia.gov/emergency-medical-services/state-strategic-and-operational-ems-plan/

Technical Assistance

EMS Workforce Development Committee

The EMS Workforce Development Committee met on February 6, 2020. The minutes of the November 8, 2019 meeting are available on the OEMS website, at the link below:
http://www.vdh.virginia.gov/emergency-medical-services/advisory-board-committees/workforce-development-committee/

One of the various goals for the committee includes the introduction of military and veterans into the Virginia EMS workforce and to support the recruitment and retention of an EMS workforce across Virginia. The committee's primary goals are to complete the EMS Officer and Standards of Excellence (SoE) programs.

EMS Officer Sub-Committee

The EMS Officer I (EMSO1) program was held at the 40th EMS Symposium with 30 registered students. 24 students successfully completed the course. Since the initial release of the EMSO1 pilot in 2016, there have been nine courses completed. In 2020, OEMS plans to hold 8-10 offerings throughout Virginia. Current offerings include: The Virginia Fire Chiefs Conference, Central Virginia EMS Expo, Caroline County Regional Fire School, Rockingham County Fire School, VAVRS Rescue College, and the 2020

Virginia EMS Symposium. In conjunction with each course offering are plans to onboard additional instructors to the EMSO1 instructor pool.

The committee is currently finalizing some adjustments to the overall program and are instituting an instructor Train-the-Trainer program. The committee plans to release the EMSO1 Course from a pilot program in early 2020. The development of the subsequent EMS Officer Courses will begin following the full release of EMS Officer 1.

The EMSO1 online education format was transitioned into a Learning Management System (LMS), utilized for the 2019 Virginia EMS Symposium course. The input from the students and instructors was extremely positive and will be utilized for future EMSO courses.

Standards of Excellence (SoE) Sub-Committee

The SoE Assessment program is a voluntary self-evaluation process for EMS agencies in Virginia based on eight Areas of Excellence (AoE) – or areas of critical importance to successful EMS agency management.

Each Area of Excellence is reviewed using an assessment document that details optimal tasks, procedures, guidelines and best practices necessary to maintain the business of managing a strong, viable and resilient EMS agency.

All documents related to the SoE program can be found on the OEMS website at the link below:
http://www.vdh.virginia.gov/emergency-medical-services/virginia-standards-of-excellence-program/

EMS Recruitment and Retention

The Virginia Recruitment and Retention Network met during the Virginia EMS Symposium at the Blue Moon Taphouse on Thursday November 7, 2019. The network is comprised of membership from Virginia, Maryland and West Virginia, with over 300 members. The network's next meeting is scheduled to meet on Thursday, February 20,

2020 from 11:30am - 1:30pm at Virginia Beach Rescue Squad Station 14. The meeting is being held in conjunction with the Virginia Fire Chief's Conference.

The mission of the Virginia Recruitment and Retention Network is "to foster an open and unselfish exchange of information and ideas aimed at improving staffing" for volunteer and career fire and EMS agencies and organizations.

Several changes have been made to the Recruitment and Retention page on the OEMS website to give it a more streamlined appearance. Links to pertinent reference documents are expected to be added to the page in the coming months.

System Assessments/Miscellaneous Technical Assistance

CHaTR staff assists the Virginia Department of Fire Programs (VDFP) with evaluations of the Fire and EMS systems in localities in Virginia.

The most recent studies were held in Southampton County, September 25-27, 2019, and in Greene County on January 27, 2020. The final reports of those studies have not been released.

Evaluation reports for previously conducted studies can be found via the link below:
https://www.vafire.com/about-virginia-department-of-fire-programs/virginia-fire-services-board/virginia-fire-services-board-studies/

ChaTR staff has been requested to conduct an EMS system study in Wise County. That study will be conducted in the first half of 2020.

CHaTR staff is also working with the VDH Office of Health Equity (OHE) to perform assessments of EMS systems that have Critical Access Hospitals (CAH) in their service areas in 2020.

Rural EMS and Mobile Integrated Healthcare/Community Paramedicine (MIH/CP)

The MIH/CP workgroup that was created in 2015 reconvened on September 19, 2018, with Dr. Allen Yee again serving as chair. The workgroup has met throughout 2019, last meeting on December 4, 2019.

Previous meeting minutes may be viewed at the link below:
http://www.vdh.virginia.gov/emergency-medical-services/community-paramedicine-mobile-integrated-healthcare/

The workgroup has created a MIH-CP white paper and a letter of intent for agencies that are performing system evaluations to determine the feasibility of providing MIH-CP

service. These documents were unanimously approved by the Medical Direction Committee at their meeting on January 16, 2020.

The *MIH-CP White Paper* (Please see **Appendix F**) and *MIH-CP Letter of Intent* (Please see **Appendix G**) are action items for advisory board approval, and are provided as attachments to this report.

The workgroup is scheduled to meet again on February 12, 2020.

The CHaTR division manager participates on the NASEMSO CP-MIH workgroup, as well as the Joint Committee on Rural Emergency Care.

The CHaTR division manager was a presenter at the Virginia Rural Health Association (VRHA) Rural Health Voice Conference on November 20 and 21, 2019 in Martinsville, and was also appointed to the VRHA Board of Directors at the same meeting. The VRHA Board of Directors met on January 24, 2020.

Division of EMS Emergency Operations

V. Division of Emergency Operations

Division of Emergency Operations Staff Members

Office Number for Staff Members 804-888-9100

Karen Owens	Emergency Operations Manager, Staff Support – Provider Health and Safety Committee karen.owens@vdh.virginia.gov
Sam Burnette	Emergency Services Coordinator, Emergency Operations Training Programs samuel.burnette@vdh.virginia.gov
Rich Troshak	Emergency Operations Specialist, Emergency Medical Dispatch Accreditation Program Staff Support - Communications Committee richard.troshak@vdh.virginia.gov
Caron Nazario	Emergency Planner, Staff Support - Emergency Management Committee caron.nazario@vdh.virginia.gov

Emergency Operations

- **Virginia General Assembly – Lobby Day**

Karen Owens participated in various meetings to support planning activities ahead of Lobby Day 2020, in anticipation of potential civil unrest during the demonstrations. The planning included securing resources to support EMS operations and ensuring OEMS preparation for other state-level activities.

Sam Burnette staffed the Emergency Services Function (ESF) #8 Public Health desk at the Virginia Emergency Operations Center (VEOC) on January 20, 2020 in support of the Governor's Emergency Declaration for Lobby Day activities related to gun control. Mr. Burnette monitored public health and emergency medical services activities providing updates to VEOC staff as needed.

- **Active Shooter Exercise**

Sam Burnette, Caron Nazario, and Karen Owens served as evaluators for an active shooter exercise sponsored by the City of Hopewell Police and Fire Departments at John Randolph Medical Center on December 11, 2019. OEMS staff provided feedback evaluation on the effectiveness of incident command and triage operations.

- **Critical Infrastructure Working Group (CIWG)**

Sam Burnette continues to serve on the Virginia Department of Emergency Management (VDEM) Critical Infrastructure Working Group attending a meeting held at the Virginia Emergency Operations Center (VEOC) on December 17, 2019. Topics discussed at this meeting included reviewing the National Strategic Framework and changes in critical infrastructure definitions and mitigation opportunities for stakeholders to protect their critical infrastructure protection.

Training Programs

- **Mass Casualty Incident Management Training Program and Train the Trainer**

Sam Burnette delivered a Mass Casualty Incident Management (MCIM) training course at the 2019 Virginia EMS Symposium on Wednesday November 6, 2019. Nineteen students from across the Commonwealth attended the training program and participated in a tabletop exercise.

On November 7, 2019, Sam provided an MCIM Train the Trainer program at the 2019 EMS Symposium to forty-four students. After completion of this training program, completing an instructor application endorsed by their agency Operational Medical Director (OMD), the students will be able to teach the MCIM I and II programs in their localities and regions.

- **National Fire Academy Health and Safety Program Manager Course**

Sam Burnette attended the 2019 Virginia State Weekend at the National Fire Academy (NFA) on November 16-17, 2019. He successfully completed the NFA Health and Safety Program Manager training course. This two-day course provides fire and emergency medical services personnel with the skills, aptitudes, and abilities to manager the duties and responsibilities of a health and safety program in their respective organizations. OEMS will use the information obtained from this course to assist EMS agencies to develop or manage their health and safety programs.

- **American Heart Association Cardiopulmonary Resuscitation(CPR) Instructor**

Sam Burnette successfully completed the American Heart Association (AHA) CPR Instructor training program held at the offices of Old Dominion EMS Alliance on Saturday November 23, 2019. Class delivered by the Virginia Commonwealth University (VCU) Center for Trauma and Critical Care Education.

- **ICS 300 Intermediate ICS for Expanding Incidents**

Caron Nazario successfully completed ICS-300 course conducted by the Prince William County Emergency Management Department. The course, held December 18 to 20th, was at the Prince William County EOC/ Government Complex. This 3-day course outlines how the NIMS Command and Coordination component supports the management of expanding incidents as well as describes the incident management processes as prescribed by ICS. This course fulfills

requirements for staffing the Virginia Emergency Operations Center (VEOC) during Virginia Emergency Support Team (VEST) activations.

- **Pandemic Preparedness and Response Training**

Caron Nazario attended this Virginia Emergency Support Team (VEST) course conducted at the Virginia Emergency Operations Center (VEOC) on Friday January 24, 2010. Virginia Department of Health facilitated the discussion surrounding the pandemic preparedness plans. This course examined the ability of ESFs to implement a flexible and unified incident management organization in response to a public health threat. The course also incorporated lessons learned from the 2019 Cardinal Resolve, Full Scale Public Health and healthcare Emergency Management Programs Exercise Series.

- **Virginia Emergency Support Team (VEST) Training**

Karen Owens attended VEST training throughout the quarter focused on a variety of topics, including EEI, Lifelines, and continuity of operations planning.

- **Community Based Emergency Response Seminar (CBERS)**

Karen participated in meetings focused on the development of the 2020 CBERS training class. This year's class focuses on mental health of emergency responders and involves representatives from the VDH-Office of Emergency Preparedness, Department of Behavioral Health and Developmental Services, the Department of Social Services, and the Department of Emergency Management.

Communications / Emergency Medical Dispatch

- **Advisory Board Communications Committee Meeting**

The Advisory Board Communications Committee met on October 22, 2019 in Roanoke, Virginia at the 2019 Virginia APCO/NENA/Interoperability Conference. This was a new venue for the meeting, which is typically held in Norfolk at the Virginia EMS Symposium. By switching to this new venue, committee members were able to meet with members of the 9-1-1 community to discuss areas of interest and concern. In addition, committee members were able to visit the vendor area to discuss and ask questions about new technologies in both the 9-1-1 centers as well as field operations.

- **Government Emergency Telecommunications Service (GETS) and Wireless Priority Service (WPS) Webinar**

On November 21, 2019, Sam Burnette, Caron Nazario, and Rich Troshak participated in a webinar conducted by the Federal Emergency Management Agency (FEMA) on updates with their GETS and WPS programs. GETS allows government officials to obtain priority on landline communications during times of high call volume associated with large-scale disasters or emergencies. WPS applies the same concept to wireless communications.

- **EMS Communications Technical Assistance**

Sam Burnette and Rich Troshak attended a meeting with the Blue Ridge EMS Council (BREMS) and Centra Hosptial in Lynchburg on December 19, 2019 to discuss interoperability issues in the region. Topics discussed included updating aging radio repeater equipment, gaps in radio coverage, coordination of air ambulance communications, and standardizing EMS agency communications with receiving hospitals.

- **Spectrum Communication Issues for First Responders Webinar**

On Friday January 17, 2020, Rich Troshak and Sam Burnette participated in a National Highway Traffic Safety Administration (NHTSA) webinar on an advanced vehicle safety technology called "vehicle to everything" communications, or V2X for short. V2X utilizes the 5.9 GHz "safety band", reserved for transportation safety purposes, to allow vehicles to share critical safety information with nearby vehicles thus improving safety for first responders and the public. NHTSA will be announcing a grant opportunity in coming weeks for public safety agencies to equip their vehicles with this new technology.

- **FirstNet**

On December 10, 2019, Karen Owens, Sam Burnette, Rich Troshak, and Caron Nazario participated in a meeting with representatives from FirstNet. The meeting provided an opportunity for OEMS staff to gain a better understanding of the FirstNet capabilities and opportunities for first responders to utilize FirstNet resources and technology.

Planning

- **Central Virginia Emergency Management Alliance (CVEMA) Monthly Meeting**

Sam Burnette and Caron Nazario attended CVEMA's November meeting held in Chesterfield County on November 21, 2019. Virginia Department of Emergency Management (VDEM) provided a presentation on scheduling Federal Emergency Management Agency (FEMA) courses in the state and region. These courses are available at no cost to the state or localities. They will be conducting a training and exercise workshop (TEPW) in Spring 2020.

Chesterfield County Fire and EMS provided a presentation on the Regional Flammable Liquids Task Force program. The program provides highly trained firefighters and equipment to respond to large flammable liquid incidents.

Another discussion involved the benefits of utilizing separate incident managers and recovery managers during disaster response. It can be difficult for an incident manager to simultaneously conduct initial response efforts and prepare for recovery. The success of recovery depends on how effectively and soon planning is conducted.

- **Virginia Emergency Operations Center (VEOC) Continuity of Operations**

On January 9, 2020, Karen Owens and Caron Nazario attended Virginia Emergency Operations Center (VEOC) training to discuss the VEOC Continuity of Operations (COOP) plan. In the event the VEOC cannot open and operate, the Virginia Department of Emergency Management (VDEM) and its partners follow the plan for alternative work locations. Discussion included the limitations associated with operating at an alternate facility.

Caron participated in a VDEM COOP exercise on January 16, 2020 designed to test the effectiveness of the COOP. Karen Owens participated as well testing the remote capabilities of a COOP activation.

- **Joint Training and Exercise Planning Workshop**

Karen Owens and Caron Nazario participated in a training and exercise workshop sponsored by the Office of Emergency Preparedness. The workshop provided an opportunity to representatives from various offices and agencies to discuss training and exercise needs and opportunities throughout the current year.

Provider Health and Safety

- **CISM – Peer Support Team Activity Reporting**

Over the course of the previous quarter, teams reported 13 activities, including education sessions, training classes, meetings, and debriefings (both group and one-on-one).

- **First Responder Mental Health Services**

Karen Owens met with representatives of the Department of Behavioral Health and Developmental Services (DBHDS) to discuss the resources available through both agencies aimed at supporting first responder's mental health.

Additionally, Karen Owens, and Vincent Valeriano, OEMS Epidemiologist, participated in multiple webinars during this quarter to learn more about resources and opportunities to support providers in the Commonwealth.

Division of Public Information and Education

VI. Division of Public Information and Education

Public Relations

Marian Hunter, Public Relations Coordinator
Tristen Graves, Public Relations Assistant

Public Outreach via Marketing Mediums

Via Virginia EMS Blog

The OEMS continues to share important updates and information via the Virginia EMS Blog. This blog replaces the EMS Bulletin, which was an online newsletter that went out twice a year. This new blog allows OEMS shares information in a more timely, concise and in a web-friendly format. It also offers more interactive features so readers can comment or ask questions through the blog.

Via Social Media Outlets

PI&E continues to keep OEMS' Twitter and Facebook pages active, educational and relevant by posting daily and/or weekly updates that provide important announcements and health-related topics to increase awareness and promote the mission of OEMS and VDH. Some of the subjects that were featured from October – December are as follows:

- **October** – Quarterly meeting of the Training & Certification Committee, Registration for the 40th Annual Virginia EMS Symposium closes Friday, Oct. 4, FREE #VaEMS2019 Symposium registrations available courtesy of the EMS for Children program, Registration closes tomorrow for the 2019 Virginia EMS Symposium, Oct. 4 is the final day to register for the Virginia EMS Symposium, Final hours to register for 40th Annual Virginia EMS Symposium, Henrico Doctors' Hospital is offering a Super Saturday - EMS CE Education course, OEMS network issues, holiday closures, CE Course Tuesdays in January 2020, 9 a.m. - 5 p.m. at Bland Volunteer Rescue Squad, Pediatric Disaster Response and Emergency Preparedness course announcement, Graduate Research project assistance request on EMT's knowledge of sports-related concussions, Spirit of Norfolk cruise, CE Course Announcement - Tuesday, Nov. 12, 2019 at Millboro Area Rescue Squad, J.R. Martinez special announcement, National First Responders Day and Celebrating 40 Years of the Virginia EMS Symposium.

- **November –** Important reminders for the 40th annual Virginia EMS Symposium, Setup begins for the Symposium, Download the Symposium app, visit the Regulation and Compliance Division booth at symposium, State EMS Advisory Board meeting announcement, Spirit Night dinner cruise tickets are now available for purchase, Biospatial Demos - Wed. & Thurs at symposium, Plan to attend General Sessions open to all attendees at symposium, Day 1 of symposium recap, General Session "Active Shooter

or Active Deadly Threat: An Approach for EMS Agencies" with Kevin Ramdayal, FDNY Captain, Thursday Night Dinner Theater tickets available for purchase, visit two exhibit halls at the Marriott and Hilton hotels, Biospatial Demos Thursday, J.R. Martinez meet and greet, vendor receptions Thursday and Friday, Thursday night dance, Friday General Session with J.R. Martinez, Randy Mantooth autograph session at Hilton hotel, vendor exhibit hall hours, symposium quick lunch options, casino Monte Carlo game night, Saturday General Session with Bob Page, Randy Mantooth autograph session at the Marriott hotel, Where in the World of EMS is A.J. Heightman? At the Virginia EMS Symposium, OEMS announces Bob Page as a Statewide CE Educator, TRA-1242 Boomer Trauma cancelled, Join us for the 2019 Governor's EMS Awards Ceremony featuring keynote speaker Randy Mantooth, final autograph session for Randy Mantooth after awards ceremony, Congratulations to the 2019 Governor's EMS Award winners, 2019 EMS Provider Mental Health Survey results and 40th annual Virginia EMS Symposium event recap, holiday office closures.

- **December** – New Process for Virginia Office of EMS Fingerprint-Based Background Checks, web portal maintenance, Call for Presentations for 2020 Symposium now open, OEMS announces multiple EMS Officer 1 program offerings coming in 2020, reminder to submit courses for the 2020 symposium call for presentations, holiday office closures.

Via GovDelivery Email Listserv (October - December)

- **11/15/19** – Press Release: Governor's EMS Award Winners Announced at the 40th Annual Virginia EMS Symposium
- **11/1/19 –** Important Reminders for the 40th Annual Virginia EMS Symposium
- **10/3/19 –** Final Days to Register: The 40th Annual Virginia EMS Symposium

Customer Service Feedback Form (Ongoing)

- PR Assistant provides monthly reports to EMS management regarding OEMS Customer Service Feedback Form.
- PR Assistant also provides biweekly attention notices (when necessary) to OEMS Director and Assistant Director concerning responses that may require immediate attention.

Training

- Dec. 10-12 – The PR Coordinator attended and completed the VDH: Leadership Essentials Certificate Program.

Social Media and Website Statistics

As of January 24, 2020, the OEMS Facebook page had 6,941 likes, which is an increase of 143 new likes since October 25, 2019. As of January 24, 2020, the OEMS Twitter page had 4,789 followers, which is a decrease of 861 followers since October 25, 2019.

Figure 1: This graph shows the total organic reach* of users who saw content from the OEMS Facebook page, October – December. Each point represents the total reach of organic users in the 7-day period ending with that day.

Our most popular Facebook post was posted on December 3, 2019. This post garnered 3.666 people reached and 873 engagements (including post likes, reactions, comments, shares and post clicks.)

**Total Reach activity is the number of people who had any content from our Facebook Page or about our Facebook Page enter their screen. Organic reach is the number of unique people who saw our post in the newsfeed or on our page, including people who saw it from a story shared by a friend when they liked it, commented on it, shared our post, answered a question or responded to an event. Also includes page mentions and check-ins. Viral reach is counted as part of organic reach. Organic reach is not paid for advertising.*

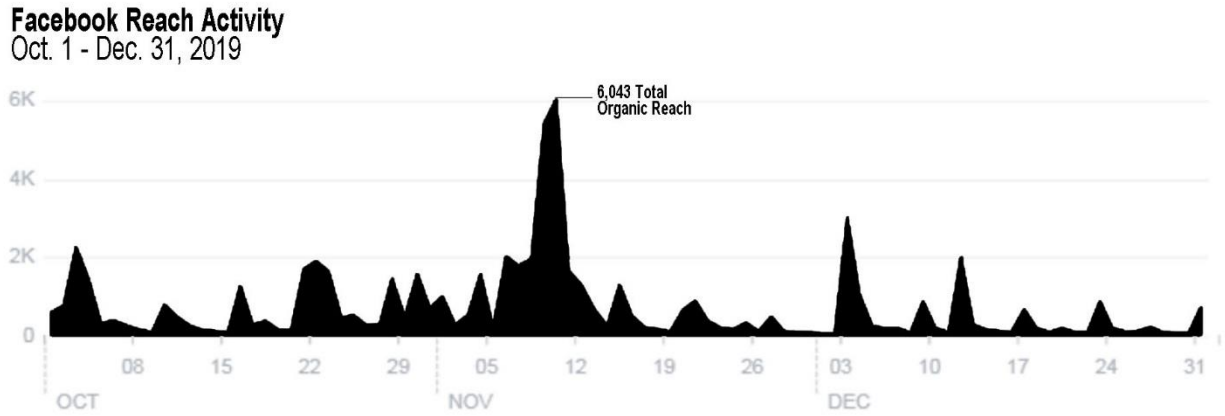


Figure 2: This graph shows the total organic impressions* over a 91-day period on the OEMS Twitter page, October - December.

During this 91-day period, the OEMS Twitter page earned 617 impressions per day. The most popular tweet received 1,767 organic impressions.

**Impressions are defined as the number of times a user saw a tweet on Twitter. Organic impressions refer to impressions that are not promoted through paid advertising.*

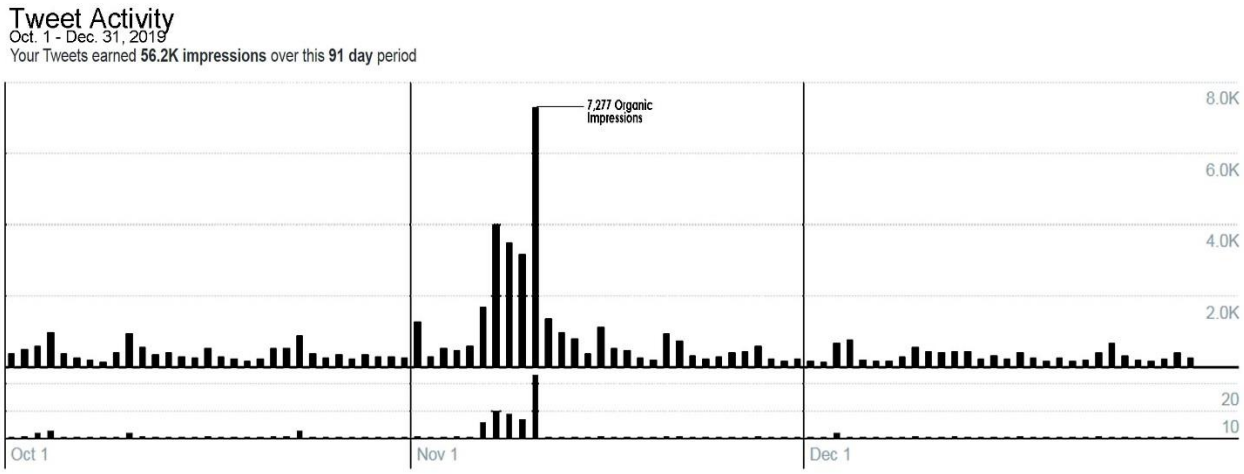


Figure 3: This table represents the top five most downloaded items on the OEMS website from October – December 2019.

October	1. Authorized Durable DNR form 2017 (321) 2. TR-06 Course Roster (243) 3. CentreLearn Instructions (242) 4. 2019 Symposium Catalog (222) 5. Scope-of-Practice-Formulary-GAB-Approved-02-08-2019 (190)
November	1. AuthorizedDurableDNRForm-2017 (341) 2. CentreLearn Instructions (215) 3. EMT Published (198) 4. TR-06 Course Roster (163) 5. TR-53A-BLS-CE-Requirements (161)
December	1. Authorized Durable DNR form 2017 (266) 2. CentreLearn Instructions (239) 3. TR-53A-BLS-CE-Requirements (182) 4. TR-06 Course Roster (176) 5. EMT Published (174)

Figure 4: This table identifies the total number of unique pageviews, the average time on the homepage and the average bounce rate for the OEMS website from October – December 2019.

	Unique Pageviews	Average Time on Page (minutes: seconds)	Bounce Rate (Average for view)
October	8,779	00:20	26.29%
November	7,457	00:20	26.39%
December	7,558	00:20	24.35%

Google Analytics Terms:

A ***unique pageview*** aggregates pageviews that are generated by the same user during the same session. A *unique pageview* represents the number of sessions during which that page was viewed one or more times.

The **average time on page** is a type of visitor report that provides data on the average amount of time that visitors spend on a webpage. This analytic pertains to the OEMS homepage.

A **bounce rate** is the percentage/number of visitors or single page web sessions. It is the number of visits in which a person leaves the website from the landing page without browsing any further. This data gives better insight into how visitors are interacting with a website.
If the success of a site depends on users viewing more than one page, then a high bounce rate is undesirable. For example, if your homepage is the gateway to the rest of your site (e.g., news articles, additional information, etc.) and a high percentage of users are viewing only your home page, then a high bounce rate is undesirable.
The OEMS website is setup in this way; our homepage is a gateway to the rest of our information, so ideally users should spend a short amount of time on the homepage before bouncing to other OEMS webpages for additional information. Generally speaking, a bounce rate in the range of 26 to 40 percent is excellent and anything under 60 percent is good.

Events

EMS Symposium

- The PR Coordinator continued to update the Symposium webpages on the OEMS website.
- PR Coordinator continued to work with the symposium sponsorship coordinator on sponsored items, inserts for symposium packets, signage requirements, etc.
- The PR Coordinator created a large-format banner in addition to large format signage for the Virginia EMS Symposium. Also finalized on-site event signage and submitted it for print.
- The PR Coordinator completed the design of the Symposium On-Site Guide and submitted it for print Oct. 23, 2019.
- The PR Coordinator continued updating information for the 2019 Symposium mobile app on Apple and Android devices.
- The PR Coordinator and PR Assistant continued promoting Symposium registration utilizing the Symposium ads that highlighted programs offered at the symposium, via social media, OEMS website and listserv email.
- The PR Assistant organized and ordered supply items that would be needed for Symposium registration packets.
- The PR Assistant finished updating the course locations into the Symposium web program.
- The PR Assistant printed name badges for Symposium attendees and organized all vendor name badges alphabetically.

- Coordinated all handouts (from sponsors and OEMS staff) to be included in the registration packets. The last week of October, OEMS staff stuffed and packed 1,800 registration packets.
- Fielded calls and emails from providers regarding registration, cancellations and vendors requesting sponsorship opportunities and the availability of vendor hall space.
- The PR Coordinator and the PR Assistant attended the 40th Annual Virginia EMS Symposium, November 6-10, 2019. Assisted with the loading and unloading of event supplies and equipment, registration and putting out signage, coordination of the Governor's EMS Awards ceremony and reception and other on-site events. Assisted with the vendor hall and updated social media sites with classroom/instructor updates and other event info.
- PR Assistant and PR Coordinator assisted with the coordination and administration of the tickets for the Thursday Night Magician Dinner Theater and the Awards Banquet.
- After the conclusion of the Symposium, the PR assistant verified CE credits and emailed Leadership and Management honorary certificates to eligible Symposium attendees who signed up for and met the certificate requirements.

Governor's EMS Awards Program

Governor's EMS Awards Program

- The PR Coordinator created the Symposium Governor's EMS Awards agenda for the table place settings.
- Prior to the event, the PR Assistant worked with the video crew to verify Governor's EMS Award nominees and winners' names, award categories and affiliations.
- The PR Assistant prepared the presentation book that contained the award winners' brief bios, which were read during the awards ceremony.
- The PR Assistant and PR Coordinator attended meetings on-site with the film crew to go over walk-thru of the Governor's EMS Awards Ceremony and the process of events for the award ceremony.
- The PR Coordinator prepared the Governor's EMS Award winners' bios and pictures and posted it on the OEMS website homepage.
- The PR coordinator sent out a statewide press release announcing the Governor's EMS Award winners November 15, 2019.
- Promoted award winners through OEMS Facebook and Twitter social media sites.
- Sent additional award winner information and photos as requested from public or media contacts.
- PR Assistant worked with the Governor's EMS Awards Nomination committee to start updating the 2020 Regional EMS Awards nomination forms. In 2019, we moved toward an electronic version of the nomination forms for the Regional EMS Councils to use.

Media Coverage

The PR Coordinator and PR Assistant are responsible for fielding the following OEMS media inquiries October – December, and submitting media alerts for the following requests:

- Oct. 3 – Reporter from the Virginian Pilot inquired about an ambulance company's federal court trial for healthcare fraud.
- Oct. 4 – Reporter from the Virginian Pilot had follow-up questions regarding media inquiry from Oct. 3.
- Nov. 19 – Reporter from CBS inquired about Richmond narcan distribution and the First Responder Recovery Program.
- Nov. 22 – Reporter from Danville Register & Bee inquired about statistics regarding female EMS personnel in Virginia.

OEMS Communications

- The PR Coordinator and PR Assistant are responsible for the following internal and external communications at OEMS:
    - On a daily basis, the PR Assistant monitors and provides assistance to the emails received through the EMS Tech Assist account and forwards messages to their respective divisions.
    - The PR Assistant is the CommonHealth Coordinator at OEMS, and as such, she sends out weekly CommonHealth Wellnotes to the OEMS staff and coordinates events within the office.
    - October – Coordinated a sock drive called, "Soctober" which helped support those in need in the Richmond area.
    - November – Coordinated a canned food drive to help support the efforts of Feed More.
- The PR Coordinator designs certificates of recognition and resolutions for designated EMS personnel on behalf of the Office of EMS and State EMS Advisory Board.
- Upon request, the PR Coordinator creates certificates for free Symposium registrations to be used at designated events.
- Upon request, the PR Coordinator and PR Assistant provide assistance for the preparation of responses to constituent requests.
- The PR Coordinator and PR Assistant respond to community requests by sending out letters, additional information, EMS items, etc.
- The PR Coordinator and PR Assistant provide reviews and edits of internal/external documents as requested.
- The PR Coordinator and PR Assistant update OEMS website with content and documents upon request from office Division and Program Managers.
- The PR Coordinator is responsible for monitoring social media activity and requests received from the public. She forwards questions to respective OEMS division managers

and provides responses to the inquiries through social media. The PR Assistant provides back-up to all social media for OEMS and VDH.

- The PR Coordinator is responsible for coordinating and submitting weekly OEMS reports to be used in the report to the Secretary of Health and Human Resources.
- The PR Coordinator assists with FOIA requests as needed.
- When applicable, the PR Assistant submits new OEMS hire bios and pictures to be included on the New Employees webpage on the VDH intranet.

VDH Communications Office

VDH Communications Tasks – The PR Coordinator and PR Assistant are responsible for covering the following VDH Communications Office tasks from October – December:

- **October - December** – The PR Coordinator is responsible for working with the Communications Office to assist with coverage for media alerts, VDH in the News, weekly Commissioner's message, media assistance, team editor and other duties upon request.
    - Beginning in June, the PR Coordinator took on the role of Acting Assistant Director in order to assist with the Communications Office due to the current director's retirement. This new role was scheduled through the October 21 when the new director was hired. The PR Coordinator continues to assist with the transition of this role to the new director and provide assistance to the Office of Communications as needed.
        - The PR Coordinator was responsible for managing staff, approving and managing marketing campaigns, approving leave, project management, procurement of assets (Granicus, Hootsuite, Adobe, etc.) conducting monthly meetings, sending out weekly commissioner's email, updating all VDH social media, updating VDH intranet and external VDH website and serving as primary contact for Adobe Stock image requests. Also assists with PR requests, including press releases, talking points, etc. and sends VDH listserv emails.
        - The PR Assistant is responsible for VDH media alerts, updating the VDH New Employees photos for the VDH intranet, replying to website feedback via the VDH website, coordinating and sending the Commissioner's clinician letters.
            - October 2 - Reporting of Lung Injury Associated with Vaping These Clinician Letters were sent through the VDH listserv, posted on the VDH website and shared via social media.

        - The PR Assistant serves as secondary backup for VDH social media, listserv emails, Adobe Stock image requests, assisting with website feedback.

- **VDH Communications Conference Calls (Ongoing) -** The PR Coordinator and PR Assistant participate in bi-weekly conference calls and polycoms for the VDH Communications team.

    - PR Coordinator and PR Assistant participate in monthly Agencywide Communications Workgroup. The PR Assistant serves on the Policies and Procedures Workgroup sub-committee and the PR Coordinator serves on the Social Media sub-committee.

Regulation and Compliance Division

VII. Regulation and Compliance

The Division of Regulation and Compliance performs the following tasks:

- Licensure
    - EMS Agencies and vehicles
- Regulatory Compliance enforcement of:
    - EMS Agencies
    - EMS Vehicles
    - EMS Personnel
    - EMS Physicians
    - RSAF Grant Verification
    - Regional EMS Councils
    - Virginia EMS Education
    - Complaint\Compliance Investigations
    - Drug Diversion Investigations
    - LCR Database Portal Management
- EMS Physician (OMD/PCD) Endorsements
- Background Investigation Unit
    - Determine eligibility for EMS certification and/or affiliation in Virginia
- EMS Regulation Variance/Exemption application determinations
- Creation and/or Revision of EMS Regulation(s)
    - Utilizing the Virginia Division of Legislative Services, Regulatory Town Hall, and Department of Planning and Budget as required
- Provide written and verbal consultation regarding proposed legislation before the Virginia General Assembly being debated or considered, that involves or impacts the delivery of EMS in the Commonwealth of Virginia

- Educational Resource specific to Virginia EMS Regulation & Compliance
    - Educational programs provided on request and during most EMS conferences throughout the Commonwealth of Virginia
- Provide support to all standing Committees of and for the State EMS Advisory Board
- Provide regulatory and compliance consultation services for EMS agencies and municipalities within the Commonwealth of Virginia
- Represent the Virginia Office of EMS, Regulation & Compliance Division on national boards and/or committees

The following is a summary of the Division's activities for the fourth quarter, 2019.

EMS Agency/Provider Compliance

Enforcement	2019 1st Quarter	2019 2nd Quarter	2019 3rd Quarter	2019 4th Quarter	2019 Totals	2018 Totals	2017 Totals
Citations	**16**	**9**	**4**	**4**	**33**	**14**	**78**
EMS Agency	1	6	3	3	13	9	37
EMS Provider	15	3	1	1	20	5	41
Verbal Warning	**4**	**2**	**0**	**2**	**8**	**10**	**5**
EMS Agency	3	1	0	0	4	8	2
EMS Provider	1	1	0	2	4	2	3
Correction Order	**1**	**1**	**3**	**0**	**5**	**5**	**30**
EMS Agency	1	0	0	0	1	4	30
EMS Provider	0	1	3	0	4	1	0
Suspension	**4**	**12**	**3**	**5**	**24**	**40**	**22**
EMS Agency	0	0	0	0	0	0	1
EMS Provider	4	12	3	5	24	40	21
Revocation	**0**	**2**	**0**	**0**	**2**	**0**	**4**
EMS Agency	0	0	0	0	0	0	0
EMS Provider	0	2	0	0	2	0	4

Compliance Cases							
EMS Opened	78	53	35	37	203	160	77*
EMS Closed	*	*	*	*	*	91	53
Drug Diversions	**1**	**4**	**1**	**1**	**6**	**12**	**20**
Variances	**21**	**36**	**23**	**30**	**110**	**54**	**8***
Approved	13	14	15	14	56	33	6
Denied	8	22	8	16	54	20	2*

Note: Not all enforcement actions require opening a compliance case. Because some actions are stand-alone, on the spot infractions, a full compliance case is not opened. Therefore, the number of enforcement actions will not equal the total number of compliance cases.

Hearings

(0) Administrative Processes Act - Informal Fact Finding Conferences (hearings) this quarter.

Licensure

Licensure	**2019 1st Quarter**	**2019 2nd Quarter**	**2019 3rd Quarter**	**2019 4th Quarter**	**2019 Total**	**2018 Total**	**2017 Total**
Total Agencies	*	586	589	587	585	607	621
New Agency	2	2	2	1	7	6	5
New Vehicles	31	70	67	71	4,326	4,243*	4,679*
Inspections	726	1007	536	550	2,819	3,729	3,089*
Agencies Inspected	93	101	68	68	330	288	319
Vehicles Inspected	546	806	389	412	2,153	3097	2,278
Unscheduled "Spot" Inspections	87	100	79	70	336	389	492*

***Note: Statistical data unavailable or incomplete at the time of this report. Data will be included as it becomes available.**

Background Investigation Unit

The Office of EMS began conducting criminal history background checks utilizing the FBI fingerprinting process through the Central Criminal Record Exchange (CCRE) of the Virginia State Police on July 1, 2014. A dedicated section with relevant information about this process is on the OEMS web site at: http://www.vdh.virginia.gov/emergency-medical-services/regulations-compliance/criminal-history-record/ .

Background Checks	2019 1st Quarter	2019 2nd Quarter	2019 3rd Quarter	2019 4th Quarter	2019 Total	2018 Total	2017 Total
Processed	1,704	1,935	2,024	1,950	7,613	7,318	7,633
Eligible	1,519	1,790	1,861	1,803	6,973 91%	6,578 89%	6,015 78%
Non-Eligible	10	10	16	11	47 <1%	48 <1%	46 <1%
Review Criminal history	47	30	58	37	172 2%	38 <1%	1,362 17%
Outstanding Waiting for results	15	8	6	1	30 <0.5%		
Rejected Fingerprint cards	113	97	83	98	391 5%		
Jurisdiction Ordinance	1073	512	453	394	2,432 31%	1,344 18%	1,167 15%

EMS Physician Endorsement

Operational Medical Directors	2019 1st Quarter	2019 2nd Quarter	2019 3rd Quarter	2019 4th Quarter	2019 Total Year End # of OMD's	2018 Total	2017 Total
Endorsed	227	223	222	220	220	*	*
New OMD's	*	*	3	0	>3	*	*
Re-Endorsed (5yr)	7	6	19	9	41	*	*
Conditional (1yr)	6	9	6	2	23	*	*
Expired Endorsement	6	4	4	5	19	*	*

The 2020 OMD workshops schedule began during EMS Symposium on November 7th and the regional schedule is posted on the Virginia Office of EMS website for the remainder of 2020.

Interested OMD's can contact the Office to register for upcoming workshops. Dr. George Lindbeck, State EMS Medical Director is reviewing and updating the on-line OMD training program that is utilized as a pre-requisite for anyone interested in becoming an endorsed EMS Physician in Virginia. A paperless (online) process for OMD initial and re-endorsement applications is being developed to submit documents via enhanced OMD portal access upgrades. One Log In for all OMD roles!

Regulatory Process Update

OEMS Regulation & Compliance Division continue to work with key EMS stakeholder groups to review suggested revisions to all sections of the current EMS Regulations (Chapter 31).

- **Stage 1** - A Notice of Intended Regulatory Action (NOIRA) posted in the Virginia Register of Regulations (Vol. 33 Issue 19) on May 15, 2017. The deadline for public comment was June 14, 2017. No public comments were submitted. OEMS Staff is working to complete the required documentation for the next step for the "Proposed" EMS Regulations.

  The approved first draft of "Proposed" EMS Regulations (Chapter 32) has been manually entered into the RIS as project 5100

  The required Town Hall (TH-02) form is complete which details all changes in regulatory language from Chapter 31 to 32 by comparison. This form was submitted to the Regulatory Town Hall on January 25, 2019.

A decision was made to hold this draft (Chapter 32) to include EMS agency regulatory language related to becoming licensed as a Mobile Integrated Healthcare-Community Paramedicine and/or Critical Care Transport service. Chapter 32 language shall also be consistent and compliant with REPLICA language.

- **Stage 2** - Submission of the completed TH-02 document for project 5100 (Chapter 32) will be presented to the VDH – Board of Health once final edits are complete; to initiate the Executive Branch Review process which requires the Office of Attorney General, Department of Planning and Budget including an Economic Impact Analysis, Cabinet Secretary, and Governor of Virginia to review; then posted for a 60 day public comment period on the Virginia Regulatory Town Hall

  Following the 60 day comment period, all comments will be considered (adopted) and final regulatory language will be revised

- **Stage 3** – Submission of the completed (TH-03) document for project 5100 as the final regulatory package via the Town Hall to again receive a repeat Executive Branch review and final public comment period before adoption into law.

- **Periodic Review for 12VAC5-66** – Regulations Governing Durable Do Not Resuscitate Orders. Submission of the completed (TH-07) document occurred this quarter. This document detailed public comments received and the suggestion that this regulation be retained in its current form. No changes are anticipated at this time.

- **2019 Annual Register of Regulations and Library of Virginia** document review and certification completed during 4th quarter of 2019- all EMS guidance documents reviewed and revised for accuracy, relevancy and compliance with all Governors Executive Orders.

  Note: All OEMS Division Managers assisted with this task by reviewing documents related to their divisions.

Additional Regulation & Compliance Division Work Activity

- ❖ The Regulation and Compliance division staff held their bi-monthly staff meeting(s) on October 7-10 and December 4-6, 2019 in Richmond, Virginia. The next divisional staff meeting is scheduled for February 12 - 14, 2020 in Glen Allen, Virginia.

- ❖ Division staff have provided technical assistance and conducted educational presentations to EMS agencies, EMS Education Coordinator Institutes and updates, and local governments as requested.

- Division field investigators have assisted the OEMS Grants Manager and the RSAF program by performing reviews of submitted grant requests as well as verification of purchase compliance for RSAF grant funds awarded during each funding cycle.

- The Office, in conjunction with VDH is in the process of creating a pathway for the re-instatement of impaired EMS providers who have been sanctioned because of a substance abuse issue. Collaborative efforts have begun with Department of Health Professions, VDH, OEMS, and Health Practitioners Monitoring Program (HPMP) to ensure consistency with project development regarding treatment and monitoring programs.

- **Process Change regarding Fingerprint submissions to the OEMS** effective January 1, 2020 the OEMS began utilizing FieldPrint for the submission of regulatory required fingerprints for criminal history record reviews to determine eligibility for both EMS certification and/or affiliation. Details of how fingerprints must be submitted to the OEMS are on the OEMS Website under Regulation & Compliance and Criminal History Record tabs.

    - Option is available to request a paper card should FieldPrint location or hours not be acceptable. These instructions are also located on the Criminal History Record tab on the OEMS website under Regulation & Compliance.
    - There is a fee for non-certified members' background checks.
        - $28.72 for non-certified member joining a volunteer agency
        - $35.72 for non-certified member joining a career agency.
        - Agencies can establish a billing account with FieldPrint to cover these fees
    - OEMS Criminal History guidance documents and FAQ's have been updated to the new FieldPrint Submission process.

- **2020 Agency Data Compliance Initiative Launched on January 1, 2020**

    - Per 12VAC5-31-560-C All licensed EMS agencies are required to submit Patient Care Records with the required minimum data set on a schedule established by the Office of EMS as authorized in §32.1-116.1 of the Code of Virginia.
    - Memo was emailed to all licensed EMS Agencies on January 10, 2020 advising of this initiative and announcing the goal of all EMS agencies are compliant by summer 2020.
    - Directions where to find the most current compliance report as well as contact information for resources to assist each EMS agency in becoming compliant were provided both in this memo and on the OEMS website under Regulation & Compliance – Data Compliance Report (sub-tab).

- Non-compliant agencies on this report will be contacted individually by their assigned OEMS Field Investigators.
- 3rd Party data vendors that submit data on behalf of licensed EMS agencies in Virginia will be contacted and notified of compliance deadline. Should data vendor remain non-compliant, their privilege to submit data to the state may be suspended.

❖ **Designated Infection Control Officer (DICO) Memo – Position update**

- DICO memo was sent to all EMS agency Superusers on December 31, 2019 and has been updated and replaced on the OEMS website under Regulation & Compliance then Compliance subtab

- The Virginia Office of EMS does not identify, approve, or endorse specific Infection Control Officer educational programs. Virginia licensed EMS agencies may select a training program of their choice to ensure their agencies DICO has received training that is compliant with OSHA Bloodborne Pathogens Standard 29 CFR 1910.1030 and any other federal regulation(s) that may apply.

❖ With the retirement of the Office of EMS Adjudication Law Judge, Mr. Robert Swander, the Regulation & Compliance Division is actively searching for available Adjudication Law Judge/Hearing Officer services to conduct pending hearings (5), as well as all future hearing requests on regulatory actions.

❖ Staffing Changes:

- Open Field Investigator position for NOVA was filled on December 10, 2019. We welcome Mr. Leonard Mascaro, NPR as the newest member of the Regulation & Compliance Team serving the Northern Virginia jurisdiction.

- Field Teams have been created and Field Investigators have been re-assigned to new supervisors. The state is now dividing into two teams (East & West)

- The eight Regulation & Compliance jurisdictions have been redrawn and assigned to evenly assign all EMS agencies among the eight Field Investigators.

    - New service area maps and jurisdictional listings are included at the end of this report. Please see **Appendix H**.

Regulation and Compliance Division Structure Profile

Ronald D. Passmore, NRP
Manager, Regulation and Compliance Division
Phone: (804) 888-9131
Fax: (804) 371-3108

Oversees the Division of Regulation and Compliance, focus is on the following broad areas:

- EMS Physician initial and re-endorsement
- EMS agency initial and re-licensure
- EMS vehicles permitting and renewal
- EMS regulations development and enforcement
- Variances and Exemptions processing for provider, agencies and entities
- OEMS policy advisor to Executive Management
- Provide technical assistance & guidance to all committees of and the state EMS Advisory Board
- OEMS Staff Liaison to the Rules and Regulations Committee
- Manages Operations Education Track for Virginia EMS Symposium
- Technical assistance to local governments, EMS agencies and providers
- Background investigations on EMS certified personnel and EMS students
- Regulatory enforcement, complaint processing
- National issues involving licensure and regulations

Marybeth Mizell

Administrative Assistant, Regulation and Compliance Division
Physician Endorsement and Background Investigation Unit
Phone: (804) 888-9130
Fax: (804) 371-3108

Provides administrative support to the Division Manager while managing all Virginia endorsed EMS physicians, to include all applications for OMD/PCD endorsement and re-endorsement, and provides technical support assistance to field team administrative assistants.

Update and maintain listing of all Virginia endorsed EMS Physicians
Provides staff support to the Rules and Regulations and Transportation committees

Kathryn "Katie" Hodges
Administrative Assistant,
Phone: (804) 888-9133

Shirley Peoples
Administrative Assistant,
Phone: (804) 888-9125

Fax: (804) 371-3409 Fax: (804) 371-3409

Provides support to field team and coordinates background investigation activities to include:

- Receiving and processing results of all fingerprint based background investigations
- Notification to agencies regarding member eligibility status per background investigations
- Assist Field Investigators (Program Representatives) with all administrative tasks
- Assist customers by navigating requests to the appropriate resource for resolution

OEMS Program Representatives (Field Investigators)

Provides field support to EMS agencies, local government, facilities and interested parties in the development of EMS to include the following:

- EMS agency initial and renewal licensure by inspections
- EMS vehicle initial and renewal permits and spot inspections
- EMS regulation development and compliance enforcement
- EMS complaint investigations
- Verify awarded EMS grants to eligible recipients from RSAF program
- Liaison and OEMS representative at various local and regional meetings with organizations to include but not limited to local governments (county, city, town), regional EMS Councils, VDEM, VDFP, OCME, federal/state and local law enforcement agencies, etc…
- Subject matter experts on the delivery of EMS within the Commonwealth
- Facilitator for matters related to OEMS through the various Office of EMS programs

Supervisor, Jimmy Burch, NRP (Jimmy.Burch@vdh.virginia.gov) – ***Virginia - East***
Wayne Berry, NRP (Wayne.Berry@vdh.virginia.gov) – *Coastal*
Steve McNeer, EMT-I (Stephen.McNeer@vdh.virginia.gov) – *Central*
Doug Layton, NRP (Douglas.Layton@vdh.virignia.gov) – *Shenandoah*

Supervisor, Paul Fleenor, NRP (Paul.Fleenor@vdh.virginia.gov) – ***Virginia - West***
Ron Kendrick, EMT-I (Ron.Kendrick@vdh.virginia.gov) – *Appalachia*
Scotty Williams, NR**P** (Scotty.Williams@vdh.virginia.gov) – *Highlands*
Len Mascaro, NRP (leonard.mascaro@vdh.virginia.gov) – *Northern Virginia*

The Regulation and Compliance Team of professionals provide the Commonwealth of Virginia with more than 144 years of combined experience specific to EMS regulations and compliance enforcement; in addition, this team of twelve has more than 313 years of combined experience with the delivery of Emergency Medical Services as clinical providers and EMS administrators.

Division of Trauma

and

Critical Care

VIII. Division of Trauma and Critical Care

Patient Care Informatics

- **Virginia Elite Updates**

    - During the 4th quarter, the Patient Care Informatics team continues to work with agencies on issues related to EMS agency data compliance. Monthly quality reports are available on the Knowledgebase so that agencies can monitor their status. The non-compliance categories include: agency failed to submit required EMS prehospital care data, agency failed to submit required demographics data, and/or submitted data not compliant with Virginia Data Dictionary requirement.

        - Support Staff continues to work with the Regulation and Compliance Division to increase agency compliance with Virginia EMS reporting requirements.
        - Overall EMS data quality monthly averages are just over 94%, with individual agency scores ranging anywhere from 0% to 100%.
        - Four hundred twenty five agencies have failed to report 2018 demographic data as outlined in the EMS Virginia Data Dictionary.
        - During this quarter, between 60 and 90 agencies failed to report anything, which includes failing to report they had no EMS runs.
        - The volume of data points submitted not compliant with the dictionary, while dropping still averages around 27,000 per month.
        - In conjunction with the Regulation and Compliance division, we are launching the 2020 EMS Data Compliance Initiative. The goal is to keep data quality and compliance issues in the forefront of EMS agencies through individual communication with both agencies and software vendors and providing training where needed to assist with improving overall quality.

- **Report Writer Upgrade**

The Report Writer module is undergoing a vendor initiated reload. The reload is anticipated to last another 2 weeks and agencies have been advised that the accuracy of data they pull cannot be guaranteed during the reload period. Once complete, the functionality of the module will be greatly enhanced and will allow for a more in-depth analysis of EMS data. OEMS will continue to update agencies as the upload progresses.

- **EMS Data Submission and Data Quality**

  Data submitted and recorded into the database contains numerous errors and missing fields. OEMS has established a scoring system that reflects whether an agency is submitting/recording information correctly. Based on this score, called "Incident Validity Score," the agencies are classified as I) Excellent, II) Good, or III) Poor. Staff works monthly with EMS agencies and the Regulation and Compliance Division to improve the quality of the data submitted to the Elite system.

  We continue to have mapping issues with agencies that have chosen to utilize their own 3rd party software product. The 3rd party vendor may allow the agency to create its own "custom codes", however these codes must then be mapped to an acceptable NEMSIS 3 data value. Of the most recent 400,000 records reviewed, over 100,000 custom/non NEMSIS 3 data elements were submitted. Support staff created individualized spreadsheets for each agency found to be submitting invalid codes that provided detailed information on the nonstandard items. We have encouraged the agencies to work with their 3rd party vendor to ensure the mapping issue is corrected. The latest Data Quality Report and Data Submission Compliance Reports are on the Knowledgebase: Knowledgebase - Data Submission Report

- *Table 1: Number of Virginia EMS Agencies Classified by Average Incident Validity Score, September-November 2019*

Validity Score Scale	September	October	November
Excellent (98-100)	408	419	405
Good (95-97.99)	54	48	45
Poor (< 95)	50	45	44
Failed to Submit	77	77	98

Table 2: Average Incident Validity Score by EMS Council Region, Fourth Quarter 2019, Virginia

EMS Council Region	October	November	December	Three Month Average
Blue Ridge	96.70	96.49	96.33	**96.52**
Central Shenandoah	99.31	97.90	93.64	**97.25**
Lord Fairfax	99.27	99.31	99.46	**99.33**
Northern	98.13	98.10	98.39	**98.19**
Old Dominion	98.96	98.92	99.00	**98.96**
Out of State/Other	96.26	96.53	97.17	**96.62**
Peninsulas	99.27	99.37	99.54	**99.38**
Rappahannock	98.73	98.70	98.70	**98.71**

Southwest	76.93	75.14	75.88	**76.03**
Thomas Jefferson	91.69	91.04	87.91	**90.46**
Tidewater	98.54	98.43	98.36	**98.45**
Western	98.98	99.08	99.04	**99.03**
Average	**96.06**	**95.75**	**95.28**	**95.74**

- **Virginia Trauma Registry**

  Work on the Trauma Registry Data Dictionary continues with an expected release date of June 2020. New validation rules will be in place and updated entry forms are in development to optimize registry data quality. In addition, a new trauma quality report is in development and is modeled after the current EMS data submission and compliance reports. Once the new dictionary entry forms and validation rules are in place, this report will be distributed each quarter. The goal of this report is to inform hospitals and trauma centers of data deficiencies and to improve data quality. The next priority is to obtain additional internal trauma registry training from the software vendor. We have new team members on board, and we want to ensure everyone is competent in the current functionality of the trauma registry system.

- **Biospatial Implementation**

  The Biospatial implementation is ongoing:

  - Security agreements are developed and they are in the approval phase.
  - The vendor has incorporated the Commonwealth of Virginia required privacy statement on the programs sign in screen.
  - Permissions groups are created and individuals will be assigned to a group that aligns with the user's job role by OEMS support staff.
  - Based interest expressed at the Biospatial booth at the 2019 Symposium, pilot agencies have been identified and will assist OEMS with the testing and roll out of the platform.

- **EMS Epidemiology**

  EMS Calls Summary: Virginia EMS agencies received/responded to **413,277** transport calls in the fourth quarter of 2019 (as of 01/24/2020). Summaries of the calls by incident disposition, sex, age, and EMS council regions are tabulated below (Tables 1-4).

Table 1: EMS Calls by Incident Disposition, Fourth Quarter 2019, Virginia

Incident Disposition	EMS Calls
Assist	28,959
Canceled	42,950
Other*	243
Patient Dead at Scene	3,305
Patient Evaluated, No Treatment/Transport Required	3,417
Patient Refused Evaluation/Care (With Transport)	1,132
Patient Refused Evaluation/Care (Without Transport)	19,008
Patient Treated, Released (AMA)	12,367
Patient Treated, Released (per protocol)	1,680
Patient Treated, Transferred Care to Another EMS Unit	4,792
Patient Treated, Transported by Law Enforcement	455
Patient Treated, Transported by Private Vehicle	244
Patient Treated, Transported by this EMS Unit	284,652
Standby	8,878
Blank	1,195
Total	**413,277**

Note: Other refers to: i) Transport of non-patient, organs, etc.; ii) Community Treatment Unit, Treated and Released; and iii) Z-TX with mutual aid transported.*

Table 2: EMS Calls by Sex, Fourth Quarter 2019, Virginia

Patient Sex	EMS Calls
Female	181,698
Male	155,757
Not Applicable	8,776
Not Recorded	18,726
Blank	5,085
Unknown (Unable to Determine)	285
Total*	**370,327**

*Note: Total does not include cancelled EMS calls.

Table 3: EMS Calls by Age Groups, Fourth Quarter 2019, Virginia

Patient Age Group (Years)	EMS Calls
Under 15	15,204
15 - 29	34,052
30 – 44	37,277
45- 59	58,422
60-75	90,126
75 and Above	102,513
Blank	32,733
Total*	**370,327**

*Note: Total does not include cancelled EMS calls.

Table 4: EMS Calls by EMS Council Region, Fourth Quarter 2019, Virginia

EMS Council Region	EMS Calls
Blue Ridge	19,738
Central Shenandoah	17,301
Lord Fairfax	10,879
Northern	71,182
Old Dominion	83,039
Out of State/Other	493
Peninsulas	35,060
Rappahannock	34,458
Southwest	27,472
Thomas Jefferson	11,561
Tidewater	62,472
Western	39,622
Total	**413,277**

- **Data Submission to ImageTrend Elite**
  - The Office of Emergency Medical Services (OEMS) provides a data management system, known as ImageTrend Elite, to Virginia EMS agencies for tracking and retaining prehospital data records. Data submitted and recorded into the database has been found to contain numerous errors and missing fields. OEMS has established a scoring system called "Incident Validity Score" which reflects whether an agency is submitting/recording information correctly. Average incident validity score by EMS council region is shown below (Table 5).

Table 5: Average Incident Validity Score by EMS Council Region, Fourth Quarter 2019, Virginia

EMS Council Region	October	November	December	Three Month Average
Blue Ridge	96.5	96.4	96.0	**96.3**
Central Shenandoah	99.2	97.7	93.2	**96.7**
Lord Fairfax	99.3	99.3	99.2	**99.2**
Northern	97.8	97.9	98.1	**97.9**
Old Dominion	98.9	98.8	98.9	**98.9**
Out of State/Other	96.2	96.3	96.9	**96.5**
Peninsulas	99.2	99.3	99.2	**99.2**
Rappahannock	98.6	98.6	98.6	**98.6**
Southwest	77.7	76.1	77.1	**77.0**
Thomas Jefferson	90.6	90.3	89.7	**90.2**
Tidewater	98.5	98.3	98.4	**98.4**
Western	98.9	99.0	99.0	**99.0**
Average	**96.7**	**96.5**	**96.5**	**96.6**

- **Opioid Usage and Naloxone Administration**

    - Virginia EMS providers administer Naloxone (Narcan) to patients with opioid overdoses. A total of 2,728 Naloxone administrations for 2,035 incident overdose cases were reported from October – December 2019. Of the Naloxone administrations provided, an improved response was identified with 1,422 of the doses; the 1,422 doses were provided for 1,181 incident overdose cases. Comparing the number of incident overdose cases (N=2,035) and the incidents with improved responses (n=1,181), 58% of the overdose cases showed positive responses to Naloxone administration.
    -

Figure 1: Naloxone Administration by Sex, Fourth Quarter 2019, Virginia

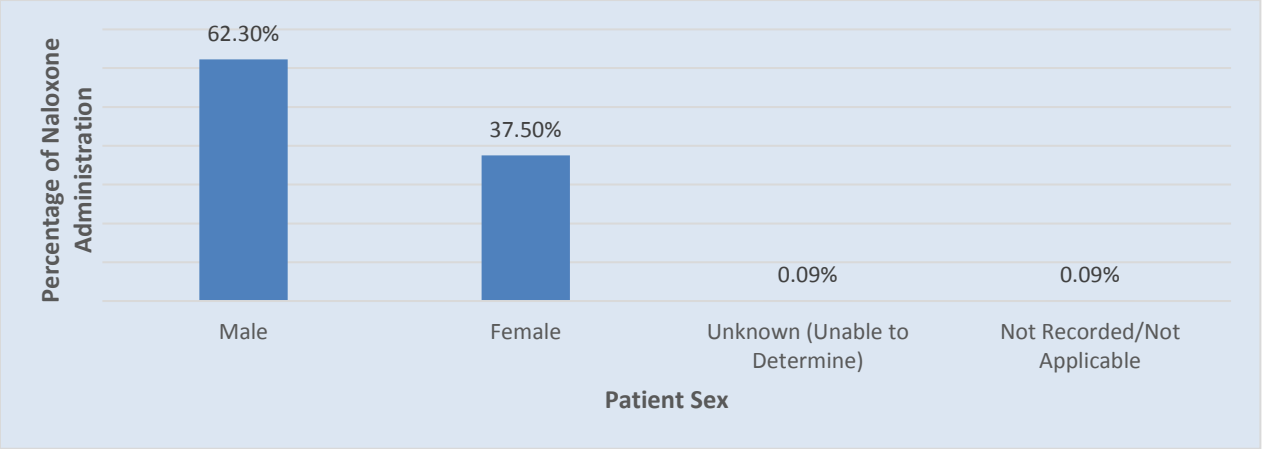


Figure 2: Naloxone Administration by Age Group, Fourth Quarter 2019, Virginia

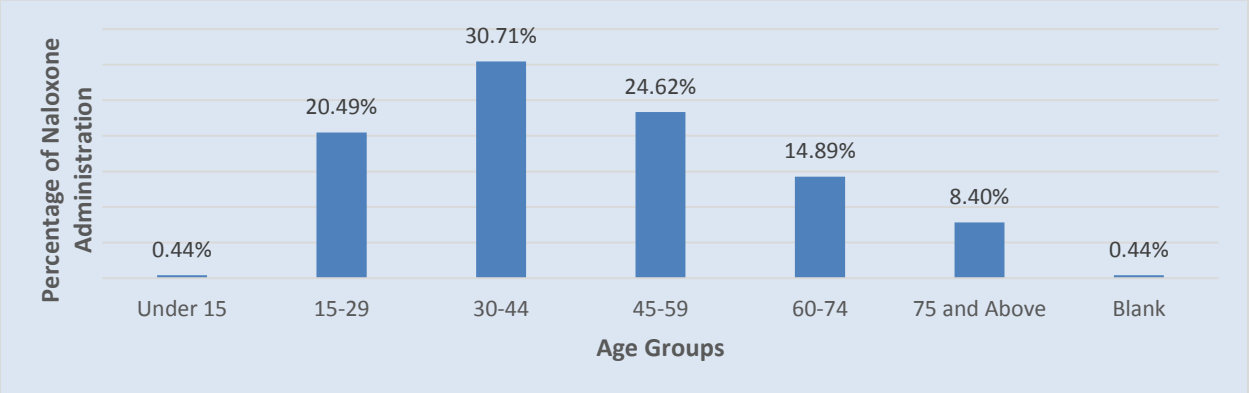


Table 6: Naloxone Administrations by EMS Council Region, Fourth Quarter 2019, Virginia

EMS Council Region	Naloxone Administrations
Blue Ridge	108
Central Shenandoah	64
Lord Fairfax	87
Northern	460
Old Dominion	751
Out of State/Other	7
Peninsulas	247
Rappahannock	238
Southwest	91
Thomas Jefferson	62
Tidewater	365
Western	248
Total	**2,728**

- **Trauma Incidents**

  - Of the total EMS calls (413,277) reported in the fourth quarter of 2019, 26,265 calls were trauma related (6.4% of the EMS call volume).

Table 7: Top Ten Injury Types, Fourth Quarter 2019, Virginia

Top Ten Injury Types	Counts of Incidents
Injury – Head	5,137
Injury – Leg	4,027
Injury – Upper Arm	3,845
Injury – Unspecified	3,567
Injury – Face	2,198
Injury – Hip	2,127
Injury – Lower Back	1,834
Injury – Neck	1,362
Injury – Thorax	784
Injury – Suicide Attempt	537

Table 8: Top Ten Hospital Destinations for Injury Calls, Fourth Quarter 2019, Virginia

Destination Hospital For Trauma Incidents	Counts of Incidents
Fairfax Hospital	1,334
Roanoke Memorial Hospital	987
VCU Health System	912
Riverside Regional Medical Center	854
Norfolk General Hospital	767

UVA Health System	763
Chippenham Hospital	742
Northern Virginia Medical Center	688
Virginia Beach General Hospital	680
Mary Washington Hospital	642

- **Ad Hoc Reports**

OEMS received a total of 16 data and/or data analysis requests in the fourth quarter of 2019.

- Request for data on sepsis patients
- OEMS analyzed EMS data from January 1, 2017 to December 31, 2018, where the type of service requested was 911 Response, the incident patient disposition was Patient treated, transported by this EMS unit, and the provider primary impression was listed as sepsis.
- In the Commonwealth of Virginia, 4,834 records in 2017 and 5,706 records in 2018 had a primary impression of sepsis documented.
- Among the patients with suspected sepsis, airway management was attempted on 82 (1.7% of Virginia total) patients in 2017 and 102 (1.8%) patients in 2018.
- Among the patients with suspected sepsis who had airway management attempted, rapid sequence induction was performed on 3 (3.7%) patients in 2017 and 9 (8.8%) patients in 2018.
- Among the patients with suspected sepsis, there were 511 (10.6% of Virginia total) patients in 2017 and 595 (10.4%) patients in 2018 who experienced hypotension.
    - Among these hypotensive patients, epinephrine was given to 2 (0.4%) patients in 2017 and 8 (1.3%) patients in 2018. Levophedrine was given to 6 (1.2%) patients in 2017 and 8 (1.3%) patients in 2018. No patients were given a combination of these medications.
- Among the patients with suspected sepsis, 2,909 (60.2% of Virginia total) patients in 2017 and 3,580 (62.7%) patients in 2018 had an IV established.
    - Among the patients with established IV, 1,282 (44.1%) patients in 2017 and 1,628 (45.5%) patients in 2018 had fluids administered.
        - Among the patients who received fluids, 375 (29.3%) patients in 2017 and 502 (30.8%) patients in 2018 had fluids administered as a bolus.
        - Among the patients who received fluids, 76 (5.9%) patients in 2017 and 68 (4.2%) patients in 2018 received the fluid as a means of keeping the veins open.

- Request for stroke data

    - OEMS analyzed EMS data from January 1, 2017 to October 31, 2019 meeting the following criteria:
        - Type of service requested was 911 Response or interfacility transport;
        - Incident patient disposition was documented as either patient treated, released (AMA); patient treated, released (per protocol); patient treated, transported by this EMS unit; patient treated, transported by law enforcement; patient treated, transported by private vehicle; or patient evaluated, no treatment/transport required; and
        - The patient had documentation of a primary impression of stroke, hemiplegia, or TIA, a primary symptom of a stroke (e.g., facial droop, aphasic speech), or a stroke scale performed.

    - In the Commonwealth of Virginia, 66,840 records met the above criteria. Of these records:

        - 59,611 were 911 responses and 7,229 were interfacility transports
        - 55,502 (83%) had an on-scene time of < 15 minutes
        - 52,805 (79%) had a blood glucose checked and recorded
        - 12,142 (18%) documented a stroke alert pre-notification
        - 57,321 (86%) had at least one stroke scale result or stroke scale type listed
            - Of the 9,519 without a stroke scale, 143 (1.5%) had a blood glucose < 60
        - 61,504 (92%) had a date/time patient last known well (esituation.18) or symptom onset date/time (esituation.01) documented
        - Time from unit notified to unit arrived on scene
            - Average: 10:42
            - Median: 7:11
        - Time from unit arrived on scene to unit left scene
            - Average: 18:38
            - Median: 16:48
        - Time from unit left scene to unit arrived at destination
            - Average: 17:29
            - Median: 13:12
    - Data was also analyzed by EMS Regional Council.

    - This data was presented at the Virginia Stroke Systems Task Force (VSSTF) Stroke Advisory Group Data Council meeting.

- **Meeting and Training Participation**

    - During the fourth quarter of 2019, epidemiology staff participated in several external meetings and training opportunities, including:

        - Fundamentals for supervisors training
        - SAS data system training
        - Tableau annual conference
        - Injury and violence prevention meeting
        - Data discussion meeting with the Department of Motor Vehicles
        - VSSTF stroke advisory group data council meeting
        - Tableau webinars
        - Naloxone publication review with VCU student researcher
        - Rappahannock EMS council board meeting

    - Additionally, epidemiology staff actively participated in the 2019 Virginia EMS Symposium. During this event, staff hosted a live demonstration of Biospatial, a data visualization platform that utilizes information from the Virginia pre-hospital reporting system. Additionally, six posters were presented at the 2019 Symposium, with a primary goal of sharing data and information with Virginia EMS providers. Poster topics included:

        - Pre-hospital data quality
        - EMS for children (EMS-C)
        - Mental health of Virginia EMS providers
        - Naloxone administrations and trauma triage
        - Compass performance measures
        - The effect of closure of a rural hospital on EMS operations in Southwest Virginia

Trauma and Critical Care

- **Trauma System Status**
    - There are currently 19 hospitals holding 23 trauma center designations: six Level I centers, six Level II centers, six Level III centers, three Pediatric centers, and two Burn centers.

Trauma Center Designation	
Hospital	**Level**
Children's Hosp. of the Kings Daughters	Ped
Chippenham Med. Ctr. (CJW-HCA)	I
Fairfax Hosp. (Inova)	I
Henrico Doctor's Hosp. (HCA)	II
Johnston-Willis Hosp. (CJW-HCA)	III
LewisGale Hosp. Montgomery (HCA)	III
Loudoun Hosp. (Inova)	III
Lynchburg General Hosp. (Centra)	II
Mary Washington Hosp.	II
New River Valley Med. Ctr. (Carilion)	III
Norfolk General Hosp. (Sentara)	I
Norfolk General Hosp. (Sentara)	Burn
Reston Hosp. Center (HCA)	II
Riverside Regional Med. Ctr.	II
Roanoke Memorial Hosp. (Carilion)	I
Roanoke Memorial Hosp. (Carilion)	Ped
Southside Regional Med. Ctr.	III
UVA	I
VCU	I
VCU	Burn
VCU	Ped
Virginia Beach General Hosp. (Sentara)	III
Winchester Med. Ctr. (ValleyHealth)	II

- Virginia Hospital Center (VHC) in Arlington has begun the process to become a Level II trauma center. VHC officially declared its intent to become a trauma center and is currently working with OEMS staff to complete its application.

- Fort Belvoir Community Hospital (FBCH) has scheduled a consultative visit from the American College of Surgeons' verification program. OEMS staff contacted staff from FBCH to advise them of the Virginia Trauma Center Designation process, and that verification from the ACS has no legal standing in Virginia. Staff there understands FBCH will not be able to hold themselves out publicly as a trauma center should they receive ACS verification.

- Naval Medical Center – Portsmouth (NMCP), previously reported as having expressed interest in becoming a Level III trauma center, reports that the efforts have been "paused" while internal issues with billing of civilians are worked out. No word on a timeline for resolution of issues or resumption of designation activities.

- **Trauma Center Site Reviews Performed / Completed Since Last Report**

  - September 26, 2019: Carilion Children's Hospital, Pediatric verification

    - Process completed: Full verification

  - October 3, 2019: Southside Regional medical Center, Level III verification

    - Process: Pending

  - October 24, 2019: Inova Fairfax Hospital, Level I verification

    - Process completed: Verified for three years

- **Trauma Center Site Reviews Scheduled / Planned for 1st Quarter 2020**

  - Norfolk General Hospital, Burn Center verification, January 23, 2020
  - Northern Virginia Medical Center, Level III provisional designation, February 14, 2020
  - New River Valley Medical Center, Level III verification, February 20, 2020
  - Chippenham Hospital, Level I verification, date TBD

- **Trauma System Committees**

    - Six of the seven Trauma System Committees met in conjunction with the EMS Symposium in Norfolk on November 5th and 6th. The Prehospital Care Committee knew in advance it would not be able to achieve a quorum on its scheduled date so that meeting was rescheduled for November 14th in Glen Allen.

- Trauma Administrative and Governance Committee (TAG) will be making room on its regular agenda to present 'special topics' that are of interest to the trauma system. If there is anything related to trauma that needs to be presented to TAG, the Chair can be contacted to place that presentation on the agenda.

- The System Improvement Committee (SIC) reviewed a quarterly report from the OEMS Epidemiology staff regarding trauma patients reported to the Virginia State Trauma Registry (VSTR). This important report will start to give SIC an idea where the trauma system needs improvement. Each TSC is being asked to review the report and decide what additional information they would find important to add to the report for their specific areas, and to create benchmarks for quality of care for trauma victims.

- The Injury and Violence Prevention Committee was unable to achieve quorum, but there were several first time members present and the opportunity was taken to help bring them up to speed on the Committee's work.

- The Acute Care Committee continues to review the Virginia Trauma Designation Manual and the Trauma Center Designation process.

- Post-Acute Care Committee is performing a comprehensive "state of the state" assessment of trauma victims sent to rehabilitation. Data will be requested from VSTR to begin this assessment.

- The Emergency Preparedness and Response Committee was unable to achieve a quorum and will work to reschedule.

- The Prehospital Care Committee began discussing the Committee's needs for the quarterly trauma report. The Committee will request that the Regional Councils drill down on the data in the report for their respective regions in order to start data-based process improvements. Trauma triage education for EMS providers was found to be lacking appropriate emphasis. Tactics for enhancing that education through CE were discussed. The Committee also began the process of determining if there are needs for updating the criteria, including creating pediatric and geriatric indicators.

- To assist with the workload associated with administering the seven TSCs, OEMS is implementing a system where OEMS Division Managers will staff the TSC meetings. This will provides high-level OEMS staff at each meeting, and allows Cam and Tim to participate in meetings as subject matter experts without the added responsibilities of meeting administration.

- **Virginia State Trauma Registry (VSTR)**

  - Work on the update of the VSTR Data Dictionary continues with an anticipated implementation of July 2020. The document, the first update to the dictionary since 2015, is currently in the 'final draft' version. It now adheres closely to the National Trauma Data Standard, extends to 200 pages, and includes 10 appendices for uniform references. Trauma/Critical Care staff continues to consult with Trauma Program Managers (TPMs) and the Association of Virginia Trauma Registrars (AVaTR). Both of these groups sent four members to a special meeting to create the initial draft. AVaTR and the TPMs have been given the opportunity to review and comment on updated versions of the draft as they were created. Trauma/Critical Care staff attended regular meetings of both groups to discuss the Dictionary and receive additional feedback. This collaboration, which collectively produced hundreds of hours of work, will ensure a thorough, high-quality, final document to guide statewide trauma data collection.

- **Virginia Stroke System Task Force**

  - The Virginia Stroke Systems Task Force (VSSTF) is an independent body comprised of stakeholders invested in improving stroke systems of care in Virginia. VDH Office of Disease Prevention provides administrative support to the VSSTF, and OEMS personnel are voting members. VSSTF meets quarterly.

  - At the November 2019 VSSTF meeting, Tim Erskine provided an overview of EMS data collection through Elite. This presentation focused on stroke-specific data collected by EMS, such as time last known well, blood sugar, stroke scale and stroke score. Hospital use of the Hospital Hub system was described since access to EMS data for stroke registries (Coverdell; Get With the Guidelines) is becoming increasingly important for stroke research.

  - OEMS personnel are assisting VSSTF with development of an EMS inventory survey to determine EMS agency needs concerning stroke care in the Commonwealth. This survey is tentatively scheduled to be sent out in early February.

VIRGINIA EMS for CHILDREN (EMSC) PROGRAM

EMSC Surveys of EMS Agencies in Progress!

The first week of January marked the launch of the 2020 EMSC Performance Measure data collection effort by all State Partnership (SP) EMSC grantees. The National EMSC Data Analysis Resource Center (NEDARC) and SP Program Managers from 58 states, U.S. territories and the freely associated states are working collaboratively to reach 18,000 EMS agencies. In Virginia, 489 agencies are being invited to participate in the survey. The focus is two-fold:

- Determine the number of EMS agencies that have identified (or plan to identify) Pediatric Champions.
- Determine the status of EMS personnel "skills-checking" on the use of pediatric equipment by the states and territories.

EMSC SP Program Managers have three months to complete data collection for the status of Performance Measures 02 and 03 from EMS agencies. The 5-10 minute online survey depends heavily on reaching legitimate contact persons at the agency level, which tends to be a moving target in many states. Much effort is being expended verifying current email addresses and validating them in the national **Contact List Management System** (CLMS) maintained by the NEDARC in Utah. All EMSC Managers are working hard to correct agency contact details as the survey progresses, and are working closely with their NEDARC Technical Assistance Liaisons to reach the 80% response threshold required by EMSC.

Focus On Developing/Identifying Pediatric Champions and Pediatric Skill Verification:

Over the next three years, the Virginia EMS for Children program will focus on identifying and supporting Pediatric Champions for EMS agencies (or in some cases groups of EMS agencies). Working with input from the Training and Certification Committee, a curriculum for Pediatric Champions is being developed, as well as clear methods for Pediatric Skills Verification for EMS providers. These two topics directly relate to national EMSC Performance Measures 02 and 03.

Follow-up Items for Pediatric Readiness at Virginia Hospitals:

Continuing EMSC recommendation (and plea) to Virginia hospital Emergency Departments:

- Weigh AND record children in **kilograms** (*to help prevent medication errors*).
- Include children specifically in hospital disaster/emergency plans.
- Designate a **Pediatric Emergency Care Coordinator** (PECC)—*nurse, physician, or both—the single most important item a hospital can implement to ensure pediatric readiness, including patient safety.*
- Ensure *pediatric* patients are included in the quality improvement process.
- Review and/or adopt **pediatric safety policies** *(radiation dosing, medication dosages, abnormal VS).*

(Summarized from the findings of the 2013 National Pediatric Readiness Assessment of hospital ED's.)

EMSC Funding Still Available to Support PEPP and ENPC

The EMSC Program is willing to support a limited number of Pediatric Education for Prehospital Professionals (PEPP) and/or Emergency Nurses Pediatric Course (ENPC) courses in regions that have difficulty in accessing pediatric training. Please let us know if you are trying to set up a course(s) and need some form of support for instructors, fees or materials in order to get these courses out there!

Additional Child Restraint Systems to be Distributed Soon:

All "ACR-4" child restraint systems previously procured by the EMSC program were distributed to Virginia EMS agencies. Another cache of child restraint systems is being ordered as we continue to emphasize that every child transported by ambulance in Virginia should be appropriately restrained.

EMS agencies are strongly encouraged to adopt safety policies and procedures requiring the use of child restraints by their providers, and the EMSC program is ready to assist. Several good resources to aid in developing these are available from the National Association of EMS Officials (NASEMSO) Safe Transport of Children Committee:

- https://nasemso.org/wp-content/uploads/Safe-Transport-of-Children-by-EMS-InterimGuidance-08Mar2017-FINAL.pdf
- https://nasemso.org/wp-content/uploads/Pediatric-Transport-Products-for-Ground-Ambulances-v2.1.pdf
- https://nasemso.org/wp-content/uploads/Challenges-Associated-with-the-Safe-Transport-of-Children-in-Ambulances-Poster-MD.pdf

If an EMS agency leader identifies an agency need to obtain one or two of these devices, he or she should contact David Edwards (david.edwards@vdh.virginia.gov) and discuss these needs in detail.

(Funding for the child restraint systems was through the EMSC State Partnership Grant [H33MC07871] via the Health Resources & Services Administration [HRSA], and administered by the Maternal and Child Health Bureau [MCHB] Division of Child, Adolescent and Family Health.)

Call for Presentations—2020 EMS Symposium:

The Virginia EMS Portal is your mechanism for proposing topics for the pediatric track at the 41st Annual Virginia EMS Symposium planned for November. Time is running out, so please submit a placeholder topic even if your complete presentation still not ready. We need quality pediatric topics—so please set aside some time this week to propose one or more pediatric related topics.

Regional Pediatric Disaster Preparedness:

Virginia EMSC also partners with regional hospital coalitions involved in the Hospital Preparedness Program (HPP) who receive funding through VDH via the Assistant Secretary of Preparedness and Response (ASPR) to improved pediatric disaster planning and readiness.

Currently we are participating in projects with two coalitions; the Near Southwest Preparedness Alliance (NSPA) and the Northwest Regional Hospital Coalition (NWRHC) in developing a Pediatric Annex to augment existing disaster and mass casualty plans in their regions. These groups are focusing on surge planning and addressing gaps in preparedness related to the pediatric population.

One of the resources being utilized by the groups utilize is findings from the 2013 *National Pediatric Readiness Assessment (NPRA)* of hospital emergency departments facilitated by the EMSC program nationally. The Virginia EMSC program customizes results from the hospital regions for comparison with state and national findings. (*The next online National Pediatric Readiness Assessment will launch in July of 2020, and will again target every hospital emergency department in the nation.)*

Volunteers Needed for EMSC Projects:

If you have passion and/or expertise concerning pediatric emergency care issues, the Virginia EMSC Program can use your assistance. Consider helping us with the following topics:

- Curriculum and resources to support *EMS agency Pediatric Champions*.
- Best practices in creating a *recognition program* for hospital emergency departments who have demonstrated a specific readiness level in caring for children (medical).
- Pediatric medication *dosing safety*.
- Evidence-based *pediatric protocols*.
- Templates for *written transfer guidelines and agreements* (that specifically refer to pediatric patients).
- Including children in hospital disaster *plans and practices*.
- Agency protocols for *restraining children during ambulance transport*.
- Local *family reunification* strategies.

Child Passenger Safety (CPS) Refresher Course—March 12:

Virginia EMSC, in conjunction with Safe Kids Virginia Coalition, is co-sponsoring a *Child Passenger Safety Refresher Course* on March 12, 2020. The all-day course will be held at the *Insurance Institute for Highway Safety (IIHS)* in Ruckersville, VA. To sign up for this course or receive more information, please contact Corri Miller-Hobbs at corri.millerhobbs@vcuhealth.org.

Suggestions/Questions

Please submit suggestions or questions related to the Virginia EMSC Program to David P. Edwards via email (david.edwards@vdh.virginia.gov), or by calling 804-888-9144 (direct line). The EMS for Children (EMSC) Program is a part of the Division of Trauma and Critical Care, within the Virginia Office of Emergency Medical Services (OEMS).

The Virginia EMSC Program receives significant funding for programmatic support through the EMSC State Partnership Grant (H33MC07871) awarded by the U.S. Department of Health and Human Services (HHS) via the Health Resources & Services Administration (HRSA), and administered by the Maternal and Child Health Bureau (MCHB) Division of Child, Adolescent and Family Health.

Respectfully Submitted

OEMS Staff

Appendix

A

Planning and Regional Coordination

Central Shenandoah EMS (CSEMS) Regional Office

Onboarding of New Program Manager

On October 10, 2019, OEMS began the onboarding process for the new CSEMS Program Manager, Daniel Linkins. After two days in the main OEMS office, meetings were conducted in the CSEMS office with Scott Winston, Assistant Director for the Office of EMS, Regional Medical Director, Asher Brand and CSEMS Board President, Gary Critzer to discuss plans and identify strategic initiatives for the upcoming year. Top priorities identified were convening the Medical Control Review Committee, setting up a council board of directors meeting (meet and greet), and revision of protocols. Additionally, the Program Manager would need to meet with other stakeholders to discuss regional needs and opportunities for support under the new structure. VDH required training has been completed, and IT access through VDH networks has been established with limited capacity.

Community Paramedicine

With growing interest in Community Paramedicine in the region, staff attended MIH/CP Workgroup meetings in Richmond. Discussions for Community Paramedicine programs are ongoing in Augusta and Rockingham counties. Augusta County has included CSEMS in upcoming meetings. Based on the final decisions from the state workgroup meetings, the CSEMS regional office hopes to provide guidance for agencies interested in program development.

Regional Coordination/Needs Assessment

To better understand the needs of agencies in the region, the CSEMS Program Manager has scheduled meetings with agency leadership to discuss priorities, needs, and opportunities for support. During 2nd Quarter FY20, staff was able to meet with leadership of Harrisonburg Rescue Squad, Highland County EMS, Blue Ridge Community College, Bath Community Hospital, Hot Springs Rescue Squad, Rockbridge County Fire-Rescue & Emergency Management, Lexington Fire & Rescue, Harrisonburg Fire Department, Rockingham County Fire & Rescue, Augusta County Fire-Rescue, and Augusta Health. Additionally, CSEMS/OEMS leadership also participated in the following local and regional meetings to assist in coordinating the regional EMS plan:

- Virginia Fire Chief's Association Board of Directors: 10/17/2019
- Rockbridge Emergency Rescue Group: 10/30/19, 12/11/19
- VSSTF Regional Collaborative Group (conference call): 11/1/19

- Rockingham Emergency Management Task Force: 11/14/19
- VDH - Building a Healthy Next Generation: 11/18/19
- Augusta County Emergency Services Officer Association: 11/18/19

State Meetings

CSEMS staff participated in the following statewide meetings and events:

- Legislative and Planning Committee: 10/16/19
- MIH-CP Workgroup Meetings: 10/23/19, 12/4/19
- Virginia EMS Symposium: 11/5/19 - 11/12/19
- State EMS Advisory Committee Meeting: 11/6/19
- Financial Assistance Review Committee: 12/5/19
- Regional EMS Council Executive Director's Meeting: 12/6/19

Regional EMS Council Meetings, Operations and Restructuring Progress

Medical Control Review Committee

- On October 29, the Medical Control Review Committee (MCRC) convened to introduce the new Program Manager, identify the scope and purpose of the committee, and organize structure for ongoing work. This meeting was largely informative in nature, but a workgroup was coordinated to revise regional protocols. The MCRC will oversee all aspects of clinical care, performance improvement, and EMS provider safety and wellness. Subcommittees and workgroups will be further identified based on specialty. The MCRC has traditionally consisted of representation of all EMS agencies and stakeholders in the region, and is thus the largest standing committee. The protocol workgroup met on the following dates during the quarter:
    - 11/12/19 09:00 - 1300
    - 11/22/19 09:00 - 12:30
    - 12/12/19 08:30 - 12:00
    - 12/27/19 08:30 - 12:00

Protocol Workgroup

- The protocol workgroup included representation from both volunteer and career services, and represented fire-based and independent rescue squads. Becky Anhold and Jacob Flickinger, OEMS contract educators, will assist in organizing and formatting of the protocols. Additionally, they will develop and implement the regional protocol course for AIC clearance. Dr. Brand led this group discussion to assure compliance with scope of practice and medical science. The process is expected to be completed in February 2020 with release and training initiated in March 2020.

Stop the Bleed

- Becky Anhold agreed to assist in teaching Stop the Bleed courses, for which the council received a grant from the Office of Health Equity, providing bleeding kits for this purpose. She will also continue teaching Certadose usage for EMT's across the region.

Educational Support and Consolidated Testing Services

- Becky Anhold will also coordinate the reorganization of the CSEMS Training Center to prepare for educational support and Consolidated Testing Services (CTS). CTS testing will be moved from a local middle school to the CSEMS Training Center as the facility is cleaned and organized to support this critical function.

CSEMS Board of Directors

- The CSEMS Board of Directors met on November 12 for a "Meet and Greet" session at the council office. Scott Winston attended the meeting for introductions and to provide an outline of the next steps in restructuring of the council. During this meeting, the board delegated authorization to Daniel Linkins to develop the employee work profiles for the additional three (3) OEMS staff assigned to the CSEMS office. Additionally, discussions ensued regarding the financial loss associated with the Pearson VUE Testing Center, and authority was delegated to Daniel Linkins to determine the best course of action. Blue Ridge Community College is interested in assuming the region's testing center, but a new site (Valley Career and Technical Center) is currently open in Fishersville, so the need for an additional site will need to be evaluated by NREMT.

Facility Management

- Staff coordinated with vendors to complete needed updates on the building exterior of the CSEMS facility, and have been working to identify furniture needs, organize offices, and remove outdated equipment from the facility. Additionally, a Real Estate Analysis was performed and submitted to the Virginia Bureau of Real Estate Services for evaluation. A formal lease agreement must be completed before OEMS can assume full maintenance responsibility and VITA can install network systems in the building.

Personnel

- Two Employee Work Profiles (EWP's) were submitted to VDH Human Resources, based on information gathered from meetings with agency leadership, review of the MOU deliverables for the regional council, and the most recent MOA established with OEMS for staffing. These positions are being reviewed and classified, and will tentatively include a Technical Resource Specialist and a Clinical Research and Quality

Improvement Coordinator. An additional Administrative Coordinator position will be developed after the program positions have been classified.

Performance Improvement

- The MCRC Committee will oversee Performance Improvement projects. These plans will need to be revised, and workgroups and subcommittees will be appointed at the next meeting. The OEMS Division of Trauma and Critical Care issued a Trauma Report for Quarter 2 (Calendar Year 2019), identifying significant under-triage in the region. An analysis was completed by OEMS regional staff to identify causes of under-triage. An analysis response was provided to the division from CSEMS, and is currently being reviewed and discussed with epidemiology staff. When complete, the final report will be provided to EMS agencies, along with specific information relevant to their own systems. Education will be provided in the region on specific data points to improve overall outcomes and data compliance.

Critical Incident Stress Management (CISM)

- The CISM committee met on October 23, 2019. The team discussed opportunities for growth, and the need to transition to more evidence-based practices. Additionally, the council is considering a transition from providing primary response to supporting development of peer support programs at the agency level. Assessments will be conducted to determine the feasibility of this transition, and assure that all localities in the region have access to the mental health support services they need. This quarter, the team responded to three (3) requests, and provided one (1) defusing and two (2) debriefings.

Consolidated Test Sites (CTS's)

- CTS Testing: CSEMS provides monthly CTS testing for EMR and EMT candidates. Statistics are listed below for CTS candidates:
    - October 16, 2019
        - 15 Testing Candidates
        - · Initial Testers: 8
        - · Re-testers: 3
        - · Re-Entry: 1
        - · Secondary Eligibility: 1
        - · EC: 0
        - · EMT: 10
        - · EMR: 5
        - · No Show: 3

- November 13, 2019 – CANCELLED DUE TO LOW REGISTRATION (2 candidates)
- December 11, 2019
  - 17 Testing Candidates
  - · Initial Testers: 15
  - · Re-testers: 2
  - · Secondary Eligibility: 0
  - · EC: 0
  - · EMT: 17
  - · EMR: 0
  - · No Show: 0

Annual Financial Audit

- The Central Shenandoah EMS Council contracted with a third party to audit financial records, in accordance with the terms of the OEMS MOU. The financial audit revealed no concerns from the auditing firm, and the fiscal year 2019 expenses were within budget.

Appendix

B

RESILIENT RESPONDER

Self-Care for Responders Before, During, & After an Emergency

3-Hour Workshop Dates and Locations:

Richmond: April 8th
Weyers Cave: April 15th
Abingdon: April 20th
Roanoke: April 21st
Fairfax: April 27th
Stafford: April 28th
Chesapeake: May 4th
Newport News: May 5th

Register Required:

http://cbers2020.eventbrite.com

Cost: FREE

Participants will learn about:

- The effects of stress and trauma on human beings
- Strategies for resilience and your ability to bounce back
- How to develop a Personal Preparedness Plan to activate if you find yourself in a stressful situation
- Various interventions related to disaster behavioral health

Target Audience: Any disaster or emergency responder

- Disaster Shelter Workers
- EOC Staff
- EMS/Fire/Law Enforcement
- Emergency Management
- Emergency Dispatch
- Emergency Department Staff
- Health Dept. and OCME Staff
- Anyone who responds to emergencies or disasters as part of their job

Brought to you by:

Virginia Department of Behavioral Health & Developmental Services

VDH VIRGINIA DEPARTMENT OF HEALTH

VIRGINIA DEPARTMENT OF SOCIAL SERVICES

VIRGINIA HOSPITAL & HEALTHCARE ASSOCIATION
An alliance of hospitals and health delivery systems

Virginia OFFICE OF EMERGENCY MEDICAL SERVICES

VIRGINIA DEPARTMENT OF EMERGENCY MANAGEMENT

Appendix

C

M. Norman Oliver, MD, MA
State Health Commissioner

Gary R. Brown
Director

P. Scott Winston
Assistant Director

COMMONWEALTH of VIRGINIA
Department of Health

Office of Emergency Medical Services
1041 Technology Park Drive
Glen Allen, VA 23059-4500

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804-888-9100
FAX: 804-371-3108

January 27, 2020

MEMORANDUM

TO: **Non-Profit Licensed EMS Agencies**

FROM: **Virginia Office of Emergency Medical Services**

SUBJECT: **Nasal Naloxone for EMS Agencies (NNEA) - Spring 2020 Cycle Announcement**

The Virginia Office of Emergency Medical Services (OEMS) is announcing a NO COST grant opportunity for licensed EMS agencies to receive nasal naloxone from January 27 to June 30, 2020. Nonprofit licensed EMS agencies residing in and serving Virginia are eligible to apply for nasal naloxone through this program. Only certified EMS personnel may administer naloxone awarded through this grant opportunity.

Eligible applicants must have either a Controlled Substance Registration (CSR) or written authorization for the shipment of naloxone from their Operational Medical Director (OMD). Applicants must also submit an address to ship the naloxone, and a phone number for their drug enforcement agent (DEA). Regional project applications must include a list of each EMS agency involved in the grant application and signed memorandum of understanding (MOU).

- Applications must be submitted through the EMS-Grant Information Funding Tool (E-GIFT). The NNEA User Guide available on the OEMS website at: https://www.vdh.virginia.gov/oems/Agency/Grants/index.htm

- Applications must be received through E-GIFT with all appropriate e-signatures by the application deadline, **June 30, 2020.**

FOR MORE INFORMATION, please check the OEMS website:
http://www.vdh.virginia.gov/oems/Agency/Grants/index.htm

OR contact Luke Parker, Grants Manager, luke.parker@vdh.virgina.gov or (804) 888-9106

Appendix

D

☒ Committee Motion: Name: Training & Certification Committee

☐ Individual Motion: Name: _____

Motion:
01-15-2020 The Training & Certification Committee moves to endorse changies the TR-90A EMT Competency Tracking Requirements for Accredited EMT Programs in Virginia.

EMS Plan Reference (include section number):

4.2.2 Assure adequate and appropriate education of EMS students.

Committee Minority Opinion (as needed):

None. There was no opposition or abtensions.

For Board's secretary use only:
Motion Seconded By: _____

Vote: By Acclamation: ☐ Approved ☐ Not Approved

By Count: Yea: _____ Nay: _____ Abstain: _____

Board Minority Opinion:

Meeting Date:

TR90A EMT Competency Tracking Requirements

for Accredited EMT Programs in Virginia

Virginia Office of EMS

Revised: January 16, 2020

EMT Competency Tracking

Purpose

The purpose of this document is to define the minimum skills and competencies required for accredited, competency-based EMT programs established from the National EMS Scope of Practice Model. The skills and competencies outlined in this document MUST be completed in a laboratory setting and verification of competency confirmed by an evaluator. It is up to the individual program based on the recommendations of its Advisory Committee and/or Medical Director to determine the applicability of skills, competencies and information not included in the TR-90A.

Table 1

This table is divided into three sections:

Individual Skill Evaluation

The individual skill evaluation will track successful performance of each individual student in a laboratory setting. While the Virginia Office of EMS only requires one successful documentation of skills, it should be understood that students will likely need repetition of these skills to depict consistency in meeting the education standard. An evaluator must verify competency via a tracking mechanism used by the program. Verification must include at a minimum, the date of successfully achieving competency and the evaluator's initials.

All skills in this area must be completed individually with the exception of the following skills that require multiple students. For the following skills, credit can be awarded to a maximum of two students at a time upon successful completion:

- Operate a stretcher
- Operate a stair chair
- Provide proper patient lifting and moving techniques
- Perform a physical restraint
- Secure a patient with a suspected spinal injury to a long board
- Perform a seated spinal motion restriction (SMR)
- Perform emergency moves for endangered patients

Individual Skill Scenario (Optional)

The individual skill scenario is suggested for student progression, but documentation of student progress is not required. Once a student has shown competency in performing an individual skill, the student may be placed in an abbreviated scenario to illustrate how the skill may be used.

If the program chooses to use the Individual Skill Scenario, verification must include at a minimum, the date of successfully achieving competency and the evaluator's initials.

The student has successfully led the team if he or she conducted a comprehensive physical assessment. This may include the direction of other Team Members to perform parts of the interview and/or physical exam. The student should formulate and implement an appropriate treatment plan for the patient. This means that most, if not all of the decisions have been made by the student, especially the formulation of a field impression, direction of treatment, determination of acuity, disposition, appropriate delegation, and when applicable, packaging/ moving the patient. A successful rating also infers that minimal to no prompting was provided by the evaluator. At no time should an action have been initiated/ performed that endangered the physical or psychological safety of the patient, bystanders, other responders, or the crew. Evaluators should not assign a successful rating unless the student performed adequately as an entry-level EMT. (NREMT, 2012)

Team Member

Demonstrates followership – is receptive to leadership; performs functions using situational awareness and maintains it; utilizes appreciative inquiry; avoids freelance activity; listens actively using closed-loop communication and reports progress on tasks; performs tasks accurately and in a timely manner; advocates for safety and is safety conscious at all times; leaves ego/rank at the door (NREMT, 2012)

Comprehensive Scenario

The comprehensive scenario provides a way to evaluate multiple skills and the critical thinking required of the student to implement these skills. During comprehensive scenarios, skills and competencies will be awarded to the Team Leader, who is ultimately responsible to ensure all skills were performed correctly and appropriately. Team Members will assist during this scenario, but will not receive credit for skills performed. Verification must include at a minimum, the date of successful completion and the evaluator's initials.

Comprehensive Scenario & Definitions

Table 2

This table lists the required minimum number and topics to be included for each student in a comprehensive scenario setting. Only the Team Leader can receive credit for the scenario(s). Students may be given credit for no more than two patient complaints in the same scenario.

Examples

Individual Skill Evaluation

Student A applies a traction splint based on the criteria of an established checklist. Student B pulls traction while Student A applies the traction splint. Only Student A should be evaluated and receive credit upon successfully achieving competency of the skill.

Individual Skill Scenario (Optional)

A brief scenario is given to the student such as, "Your patient has a fractured femur and you are now ready to splint the fracture. Please demonstrate how you would appropriately manage this injury." Student B pulls traction while Student A applies the traction splint. Only Student A should be evaluated and receive credit upon successful completion of the skill.

Student A is the Team Leader and will be given a comprehensive scenario that requires a full assessment and critical thinking to determine a potential femur fracture is present and how to appropriately manage the injury. Student B is the Team Member for this scenario.

During a comprehensive scenario, only Student A will receive credit for skills performed or delegated to others. Up to two patient complaints from Table 2 may be used during a single scenario. For example, a patient in active childbirth may also have abdominal pain and suffer an asthma attack, but only credit may be awarded for two of the three complaints listed. Programs are encouraged to include multiple skills within a comprehensive scenario. See the attached mapped scenario for more details.

Team Leader

Creates an action plan; communicates accurately and concisely while listening and encouraging feedback; receives, processes, verifies, and prioritizes information; reconciles incongruent information; demonstrates confidence, compassion, maturity and command presence; takes charge; maintains accountability for team's actions/outcomes; assess situation and resources and modifies accordingly.

Trauma	Fall w/ Wrist fracture-Geriatric DLOC Jane Smith, 70 y.o. female Retired secretary	

Case Overview:	This case presents as a 70 year old white female who is confused, with a visible contusion to the R forehead and obvious deformity to R wrist, following a fall from a standing position.
Dispatch Information:.	You are dispatched to a single family residence for an injury from a fall. You are the lead EMT for an EMS crew on a BLS ambulance in a suburban area. You have a BLS partner to assist you. You are dispatched as a single unit and are 20 minutes from the local community hospital (with PCI and Stroke capability). You are 40 minutes from the nearest level 1 trauma center.
Time / Weather:	It is 10 PM on a Thursday evening in the winter. The temp is 30 degrees with a slight wind chill and light ice patches on the ground.
Scene Information:	You arrive on scene to a small home in a suburban neighborhood. There is a porch light on, dim and inadequate
General Impression	You approach the residence to find a woman sitting on the ground of a dark driveway, with a man kneeling beside her. The man waves you over.
Patient Information	You see a moderately overweight, approximately 200 lbs, white female sitting on the ground outside in slacks and a thin sweater and slippers.

Primary / Initial Assessment ****Only give the following information if the learner asks about it or verbalizes what they see regarding each finding.***

Mental Status:	CAO x 2 (person, place, time) -Does not remember the fall-appears confused
Chief Complaint:	"My wrist hurts. What happened?"
Airway:	Patent
Breathing rate / rhythm / quality:	Tachypneic without any accessory muscle use. Non-labored.
Initial Lung Sounds:	Clear bilaterally.
Pulse rate / rhythm / quality:	Weak, regular, rapid
Skin color / temperature / condition / bleeding:	Pale, cool and dry

Secondary Assessment: Subjective (Interviewing) Objective (Physical Findings)	**Subjective (Interviewing)**	**Objective (Physical Findings)**	
Onset	Husband states the patient was just walking to the mailbox when she fell.	Head	Large 2" contusion to R side of forehead
		Neck	Normal exam
		Thorax	Normal exam
Provocation	Head- nothing.Wrist- movement	Abdomen	Normal exam
Quality	Head- dull aching at site. Wrist- sharp upon movement	Pelvis	Normal exam
Radiation	None	Left Leg	Normal exam
Severity	Pt. appears confused by pain scale question, but says "it hurts!"	Right Leg	Normal exam
Time since onset	20 minutes	Left Arm	Normal exam
Signs and Symptoms	Pain and deformity of the right wrist and a large 2" contusion to the R forehead. No nausea, vomiting, dizziness or blurred vision, chest pain, syncope, or difficulty breathing.	Right Arm	Obvious deformity to wrist, PMS present
Allergies	NKDA	Posterior	Normal exam
Medications	Remicade, Fluoxetine, Glucophage, calcium supplement, Colace, Duragesic, Inderal	12 Lead	N/a
Past medical history	Diabetes, Appendectomy, GERD, Osteoporosis, chronic back pain, HTN, depression		
Last oral intake	Dinner at 6:30. Chicken casserole.		
Events Leading Up to	Walking to mailbox		

Trauma	Fall w/ Wrist fracture-Geriatric DLOC Jane Smith, 70 y.o. female Retired secretary	

Vital Signs & Reassessment Info

	1st set	Removal from cold	Splint wrist	Glucose Admin	2 mins post Glucose	
Mental Status / Neuro	CAO x 2 (does not remember fall)	No change	No change	No change	CAOx3	
Pupils	PERRL – 4 mm	No change	No change			
Heart Rate	124 S Tach	No change	130 S Tach		114	
Blood Pressure	110/82	No change	106/88		108/84	
RR	24	No change	22		18	
SpO2	97%	98%	98%		97%	
EtCO2	35 square	No change	No change			
Lung Sounds	Clear bilaterally	No change	No change			
Severity Rating	N/A	No change	no change		6 out of 10	
Skin	Pale, cool, dry	Pale, warm, dry	Pink, warm, dry			
Temperature	97.2	No change	98.4			
Blood Glucose	48	no change	no change		122	
Capillary refill	4 sec	no change	no change			
Major Life Threats:	Hypoglycemia					
Correct Treatment:	Immobilization of pt's wrist, Glucose administration					
Diagnosis:	Confusion due to hypoglycemic event, which led to a fall.					

Competencies

Preparatory	T1	T2	T3	T4	T5	T6	T7	T8	T10	T11	T12	T14	T17	T18				
Airway	T22	T29																
Med	T37	T39																
Trauma	T56																	

Virginia Office of EMS

TR90A EMT Compentency Tracking

Accredited Program #:

Sponsor/Institution Name:

Programs must track at least all of the procedures listed below.

The tables below have been populated with the OEMS Required Minimum Numbers of student competencies for each listed category. If the program required minimum number(s) differ(s) from the OEMS Required Minimum Number(s), the number(s) in the Program Required Minimum Numbers column should be adjusted accordingly. If desired, programs can determine their own required minimum number for any student competency category that does not contain a OEMS Recommended Minimum Number.

Programs must establish and require minimum numbers of student competencies (i.e., skills, patient ages, differential diagnosis or complaints, team leads, etc). The minimum competency numbers must be approved by the Medical Director, endorsed by the Advisory Committee, and documented in Advisory Committee minutes. Program tracking documentation must show 100% of program graduates have met 100% of the program minimums. There must be documented periodic evaluation of the established minimums to determine ongoing graduate competency.

NOTE: Programs holding the status of Letter of Review (LoR) MUST also establish and track minimum competencies to ensure graduate competency.

TABLE 1

	Sequence of Learning Progression:	Individual Skill Evaluation →		Individual Skill Scenario →		"Putting it all together" Evaluation of Skills in a Comprehensive Laboratory Scenario	
Comptency Number	Required Competencies and Skills *must have at least one successful instructor evaluated and documented performance before starting the related individual skill scenario	Number of Successful Times an Individual Student Competency Evaluation in the Laboratory (Min # of Times)		Individual Student Competency Evaluation in a Laboratory Scenario (Min # of Times)		Comprehensive Skill Competency Performed and Evaluated in a Laboratory Scenario (Total Min # of Times)	
		VAOEMS Required	Program Required Minimum	VAOEMS Recommended	Program Required Minimum	VAOEMS Required	Program Required Minimum
	Preparatory						
P1	Select, don, doff and properly/safely discard PPE	1		1		2	
P2	Determine a patient's level of consciousness	1		1		2	
P3	Assess a patient for a patent airway	1		1		2	
P4	Assess a patient for breathing and provide depth, rate, quality	1		1		2	
P5	Acquire a pulse and provide rate, rhythm, and strength	1		1		2	
P6	Assess the skin color, temp, and moisture, turgor and external bleeding	1		1		2	
P7	Assess capillary refill	1		1		2	
P8	Assess the pupils as to equality, size, reactivity, accommodation	1		1		2	
P9	Obtain an automated blood pressure	1		1		2	
P10	Obtain a manual blood pressure	1		1		2	
P11	Obtain a SAMPLE history	1		1		2	
P12	*Operate a stretcher	1		1		2	
P13	*Operate a stair chair	1		1		2	
P14	*Provide proper patient lifting and moving techniques	1		1		2	
P15	Perform a simulated, organized, concise radio transmission (lab setting)	1		1		2	
P16	Perform patient report that would be given to staff at receiving facility (lab setting)	1		1		2	

Virginia Office of EMS

TR90A EMT Compentency Tracking

P17	Perform report that would be given to ALS provider in (lab setting)	1		1		2	
P18	Complete pre-hospital care report (lab setting)	1		1		2	
	Airway						
A1	Perform head tilt, chin-lift maneuver	1		1		2	
A2	Perform a jaw thrust maneuver	1		1		2	
A3	Perform upper airway suctioning using soft/rigid suction devices	1		1		2	
A4	Assemble and operate an oxygen tank	1		0		0	
A5	Ventilate using a BVM at the appropriate rate	1		1		2	
A6	Ventilate patient with a stoma	2		0		0	
A7	Insert an OP airway during an airway	1		1		2	
A8	Insert a NP airway during an airway	1		1		2	
A9	Use a non-rebreather and adjust oxygen flow requirements needed	1		1		2	
A10	Use a nasal cannula and adjust oxygen flow requirements needed	1		1		2	
A11	Use and interpret pulse oximetry	1		1		2	
A12	Apply CPAP	1		1		2	
	Medical						
M1	Administer a meter dose inhaler	1		1		2	
M2	Administer a aerosolized/nebulizer medication	1		1		2	
M3	Administer an intramuscular medication via auto-injector	1		1		2	
M4	Administer an intramuscular medication - premeaured unit-dose	1		1		2	
M5	Administer intranasal medication - premeasured unit-dosed	1		1		2	
M6	Administer mucosal/sublingual medication	1		1		2	
M7	Administer oral medication	1		1		2	
M8	Apply and obtain a 12 lead ECG	1		1		2	
M9	Perform blood glucose monitoring	1		1		2	
M10	Assist with a normal delivery	1		1		1	
M11	Assist with a complicated delivery	1		1		1	
M12	*Perform a physical restraint	1		1		2	
	Trauma						
T1	Perform hemorrhage control – direct pressure	1		1		2	
T2	Perform hemorrhage control – tourniquet	1		1		2	
T3	Perform hemorrhage control – wound packing	1		1		2	

Virginia Office of EMS

TR90A EMT Compentency Tracking

T4	Provide care for eye injuries	1		1		2	
T5	Provide care for epistaxis	1		1		2	
T6	Provide care for an open neck wound	1		1		2	
T7	Provide care for an open chest wound	1		1		2	
T8	Provide care for an open abdominal wounds	1		1		2	
T9	Provide care for an open junctional injury	1		1		2	
T10	Provide care for an impaled object	1		1		2	
T11	Provide care for a patient with an amputation and the amputated part	1		1		2	
T12	Provide care for a patient with burns	1		1		2	
T13	Perform immboilization of a long bone - traction	1		1		1	
T14	Perform immboilization of a long bone - rigid	1		1		1	
T15	Perform immboilization of a long bone - soft	1		1		1	
T16	Perform immobilization of a joint - pillow	1		1		1	
T17	Perform immobilization of a joint - sling & swathe	1		1		1	
T18	Perform immobilization of a joint - rigid	1		1		1	
T19	Provide care for a patient with a suspected hip/pelvis fracture	1		1		2	
T20	*Secure a patient with a suspected spinal injury to a long spine board	1		1		2	
T21	*Perform seated SMR (KED, etc.)	1		1		2	
T22	*Perform emergency moves for endangered patients	1		1		2	
T23	Manage a patient with a helmet	1		1		2	
	Totals	66	0	63	0	118	0

Virginia Office of EMS

TR90A EMT Compentency Tracking

TABLE 2

Simulation Pathology or Patient Complaint (these simulations must be high fidelity, comprehensive simulations using high fidelity manikins or programmed patients with appropriate accessory equipment to actually perform required skills).	Program Required Minimum #	
	Pediatric	Adult / Geriatric
Abdominal Pain	1	1
Allergic Reaction		1
Anaphylaxis with epi administration	1	1
Chest Pain with ASA/NTG Administration		2
Chest Pain with NTG Contraindicated		1
Delivery with Neonatal Resuscitation	2	
Hypoglycemia - Conscious with glucose administration		2
Hypoglycemia or DKA or HHNS - Unconscious	1	1
Obstetric or Gynecologic		2
Overdose (non-opioid)		1
Overdose with opioid antagonist administration	1	2
Poisoning with antidote administration		1
Psychiatric	1	2
Respiratory Distress and/or Failure - Asthma/COPD with bronchodilator administration	1	1
Respiratory Distress and/or Failure - CHF		2
Seizure	1	1
Sepsis	1	1
Shock	1	1
Stroke (non-LVO)		1
Stroke-Occlusive (LVO)		1
Trauma (blunt, penetrating, burns, or hemorrhage)	2	4
Total number of scenarios required for each student:	**42**	

Medical Director Approval Required

Printed Name	**Signature**	**Date**

Program Director Approval Required

Printed Name	**Signature**	**Date**

Advisory Committee Endorsement Required

Minutes where endoresment approved | **Date**

Virginia
OFFICE OF EMERGENCY MEDICAL SERVICES
Virginia Department of Health

TR90A EMT Student Competency Tracking Form

Student Name _____ **OEMS Student Certification #** _____

Instructions

The student will be evaluated on each competency, at a minimum, as listed in the attached table. The evaluator will award a scaore from the list below, initial, and date the appropriate block. At the course completion, all skill areas must be completed to signify eligibility for certification testing.

Scoring

Pass	Successful/Competent; no prompting necessary – The student performed at the entry-level of competency as judged by the preceptor. Entry-level of competency takes into account the amount of education the student has undergone at the time of education.
Fail	Unsuccessful – required critical or excessive prompting; inconsistent; not yet competent; this includes "Not attempted" when the student was expected to try. The student performed with some errors of commission or omission that would lead the preceptor to a conclusion that the student did not meet competency in the skill being evaluated.

Example

Preparatory Competencies								
		Individual Skill Evaluation	**Individual Skill Scenario**	**Comprehensive Scenario**				
Demonstrates the ability to correctly:		**Performed**				**Remediation, *as needed***		
P1	Select, don, doff and properly/safely discard PPE	WWD 12/01/19 ☑Pass☐Fail	☐Pass☐Fail	WWD 01/05/20 ☑Pass☐Fail	WWD 01/09/20 ☑Pass☐Fail			

Virginia Office of EMS

TR90A Compentency Tracking Summary

Preparatory Competencies

		Individual Skill Evaluation	Individual Skill Scenario	Comprehensive Scenario				
Demonstrates the ability to correctly:		**Performed**				**Remediation, *as needed***		
P1	Select, don, doff and properly/safely discard PPE	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail			
P2	Determine a patient's level of consciousness	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail			
P3	Assess a patient for a patent airway	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail			
P4	Assess a patient for breathing and provide depth, rate, quality	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail			
P5	Acquire a pulse and provide rate, rhythm, and strength	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail			
P6	Assess the skin color, temp, and moisture, turgor and external bleeding	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail			
P7	Assess capillary refill	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail			
P8	Assess the pupils as to equality, size, reactivity, accommodation	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail			
P9	Obtain an automated blood pressure	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail			
P10	Obtain a manual blood pressure	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail			
P11	Obtain a SAMPLE history	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail			
P12	*Operate a stretcher	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail			
P13	*Operate a stair chair	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail			

P14	*Provide proper patient lifting and moving techniques	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail			
P15	Perform a simulated, organized, concise radio transmission (lab setting)	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail			
P16	Perform patient report that would be given to staff at receiving facility (lab setting)	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail			
P17	Perform report that would be given to ALS provider in (lab setting)	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail			
P18	Complete pre-hospital care report (lab setting)	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail			
Airway Oxygen & Ventilation Competencies								
		Individual Skill Evaluation	**Individual Skill Scenario**	**Comprehensive Scenario**				
Demonstrates the ability to correctly:		**Performed**				**Remediation, *as needed***		
A1	Perform head tilt, chin-lift maneuver	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail			
A2	Perform a jaw thrust maneuver	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail			
A3	Perform upper airway suctioning using soft/rigid suction devices	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail			
A4	Assemble and operate an oxygen tank	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail			
A5	Ventilate using a BVM at the appropriate rate	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail			
A6	Ventilate patient with a stoma	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail			
A7	Insert an OP airway during an airway	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail			
A8	Insert a NP airway during an airway	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail			

A9	Use a non-rebreather and adjust oxygen flow requirements needed	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail			
A10	Use a nasal cannula and adjust oxygen flow requirements needed	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail			
A11	Use and interpret pulse oximetry	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail			
A12	Apply CPAP	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail			
Medical, Behavioral & OB/GYN Competencies								
		Individual Skill Evaluation	**Individual Skill Scenario**	**Comprehensive Scenario**				
Demonstrates the ability to correctly:		**Performed**				**Remediation, *as needed***		
M1	Administer a meter dose inhaler	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail			
M2	Administer a aerosolized/nebulizer medication	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail			
M3	Administer an intramuscular medication via auto-injector	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail			
M4	Administer an intramuscular medication - premeaured unit-dose	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail			
M5	Administer intranasal medication - premeasured unit-dosed	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail			
M6	Administer mucosal/sublingual medication	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail			
M7	Administer oral medication	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail			
M8	Apply and obtain a 12 lead ECG	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail			
M9	Perform blood glucose monitoring	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail			

M10	Assist with a normal delivery	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail			
M11	Assist with a complicated delivery	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail			
M12	*Perform a physical restraint	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail			
Trauma Competencies								
		Individual Skill Evaluation	**Individual Skill Scenario**	**Comprehensive Scenario**				
Demonstrates the ability to correctly:		**Performed**				**Remediation, *as needed***		
T1	Perform hemorrhage control – direct pressure	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail			
T2	Perform hemorrhage control – tourniquet	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail			
T3	Perform hemorrhage control – wound packing	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail			
T4	Provide care for eye injuries	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail			
T5	Provide care for epistaxis	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail			
T6	Provide care for an open neck wound	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail			
T7	Provide care for an open chest wound	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail			
T8	Provide care for an open abdominal wounds	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail			
T9	Provide care for an open junctional injury	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail			
T10	Provide care for an impaled object	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail			

Virginia Office of EMS

TR90A Compentency Tracking Summary

T11	Provide care for a patient with an amputation and the amputated part	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail			
T12	Provide care for a patient with burns	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail			
T13	Perform immboilization of a long bone - traction	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail			
T14	Perform immboilization of a long bone - rigid	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail			
T15	Perform immboilization of a long bone - soft	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail			
T16	Perform immobilization of a joint - pillow	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail			
T17	Perform immobilization of a joint - sling & swathe	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail			
T18	Perform immobilization of a joint - rigid	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail			
T19	Provide care for a patient with a suspected hip/pelvis fracture	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail			
T20	*Secure a patient with a suspected spinal injury to a long spine board	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail			
T21	*Perform seated SMR (KED, etc.)	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail			
T22	*Perform emergency moves for endangered patients	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail			
T23	Manage a patient with a helmet	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail	☐Pass☐Fail			

Appendix

E

☒ Committee Motion: Name: Medical Direction Committee

☐ Individual Motion: Name: _____

Motion:
01-16-2020 - The Medical Direction Committee moves to endorse changs to the VA EMS Scope of Practice Formulary Schedule as follows:
a) Clarification on EMT transport of a patient with IV fluids to read as follows: EMT may transport patient with IV fluids not requiring titration or adjustment, and without additives including electrolytes (e.g. potassium, magnesium) not requiring titration or adjustment, and without additives including electrolytes (e.g. potassium, magnesium).

b) Clarification on EMT administration of Epinephrine for Anaphylaxis to read as follows: Note: Med-Math skills including dosage calculations and measurement of medication to be administered are outside EMT scope of practice. EMT's may draw epinephrine from vials or ampules for the treatment of acute allergic reactions using devices/systems using syringes with mechanical limiters or color-coded or other clearly marked indicators to allow accurate dose measurement.

c) Under Hormones, added: Other Hormones (pitocin, octreotide, prostaglandins)

EMS Plan Reference (include section number):

3.1.7 Through a consensus process, develop a recommendation for evidence-based patient care guidelines and formulary.

Committee Minority Opinion (as needed):

None. There was no opposition or abtensions.

For Board's secretary use only:
Motion Seconded By: _____

Vote: By Acclamation: ☒ Approved ☐ Not Approved

By Count: Yea: _____ Nay: _____ Abstain: _____

Board Minority Opinion:

Meeting Date: January 16, 2020

Virginia Office of Emergency Medical Services
Scope of Practice - Procedures for EMS Personnel

This SOP represents ***practice maximums*** .

PROCEDURE	SKILL	PROCEDURE SUBTYPE	EMR	EMT	AEMT	I	P
Specific tasks in this document shall refer to the Virginia Education Standards.							
AIRWAY TECHNIQUES							
Airway Adjuncts							
	Oropharyngeal Airway		●	●	●	●	●
	Nasopharyngeal Airway		●	●	●	●	●
Airway Maneuvers							
	Head tilt jaw thrust		●	●	●	●	●
	Jaw thrust		●	●	●	●	●
	Chin lift		●	●	●	●	●
	Cricoid Pressure		●	●	●	●	●
	Management of existing Tracheostomy			●	●	●	●
Alternate Airway Devices							
	Non Visualized Airway Devices	Supraglottic		●	●	●	●
Cricothyrotomy							
	Needle						●
	Surgical	Includes percutaneous techniques					●
Obstructed Airway Clearance							
	Manual		●	●	●	●	●
	Visualize Upper-airway				●	●	●
Intubation							
	Orotracheal - Over Age 12					●	●
	Nasotracheal						●
	Pediatric - Age 12 and under						●
	Drug assisted intubation (DAI) all ages	Includes:					●
		Drug facilitated intubation (DFI)					
		Delayed sequence intubation (DSI)					●
		Rapid sequence intubation (RSI)					●
	Confirmation procedures			●	●	●	●
**** Endotracheal intubation is prohibited for all levels except Intermediate and Paramedic**							
Oxygen Delivery Systems							
	Nasal Cannula		●	●	●	●	●
	Venturi Mask			●	●	●	●
	Simple Face Mask		●	●	●	●	●
	Partial Rebreather Face Mask			●	●	●	●
	Non-rebreather Face Mask		●	●	●	●	●
	Face Tent			●	●	●	●
	Tracheal Cuff			●	●	●	●

"Investigational medications and procedures which have been reviewed and approved by an Institutional Review Board (IRB) will be considered to be approved by the Medical Direction Committee solely within the context of the approved study. Investigators involved in IRB approved research are asked to present their study plans to the MDC for informational purposes so that the committee can maintain an awareness of on-going pre-hospital research in the Commonwealth. Those who desire to conduct non-IRB reviewed pilot projects, demonstration projects, or research are asked to present those proposals to the MDC prior to their implementation for review and approval by the MDC."

Use of medication not listed which is indicated by medical control and/or the operational medical director due to the use of a weapon of mass destruction is exempt from this list.

Virginia Office of Emergency Medical Services
Scope of Practice - Procedures for EMS Personnel

This SOP represents ***practice maximums*** .

PROCEDURE	SKILL	PROCEDURE SUBTYPE	EMR	EMT	AEMT	I	P
	Oxygen Hood					●	●
	O2 Powered Flow restricted device			●	●	●	●
	Humidification			●	●	●	●
Suction							
	Manually Operated		●	●	●	●	●
	Mechanically Operated		●	●	●	●	●
	Pharyngeal		●	●	●	●	●
	Bronchial-Tracheal			●	●	●	●
	Oral Suctioning		●	●	●	●	●
	Naso-pharyngeal Suctioning			●	●	●	●
	Endotracheal Suctioning			●	●	●	●
	Meconium Aspiration Neonate with ET						●
Ventilation – assisted / mechanical							
	Mouth to Mask		●	●	●	●	●
	Mouth to Mask with O2		●	●	●	●	●
	Bag-Valve-Mask Adult		●	●	●	●	●
	Bag-Valve-Mask with supplemental O2 Adult		●	●	●	●	●
	Bag-Valve-Mask with supplemental O2 and reservoir Adult		●	●	●	●	●
	Bag-Valve-Mask Pediatric		●	●	●	●	●
	Bag-Valve-Mask with supplemental O2 Pediatric		●	●	●	●	●
	Bag-Valve-Mask with supplemental O2 and reservoir Pediatric		●	●	●	●	●
	Bag-Valve-Mask neonate/infant		●	●	●	●	●
	Bag-Valve-Mask with supplemental O2 Neonate/Infant		●	●	●	●	●
	Bag-Valve-Mask with supplemental O2 and reservoir Neonate/Infant		●	●	●	●	●
	Noninvasive positive pressure vent.	CPAP, BiPAP, PEEP		●	●	●	●
	Jet insuflation						●
	Mechanical Ventilator (Manual/Automated Transport Ventilator)	Maintain long term/established			●	●	●
		Initiate/Manage ventilator				●	●
Anesthesia (Local)						●	●
Pain Control & Sedation							
	Self Administered inhaled analgesics			●	●	●	●
	Pharmacological (non-inhaled)				●	●	●
	Patient controlled analgesia (PCA)	Maintain established			●	●	●
	Epidural catheters (maintain)	Maintain established				●	●

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Virginia Office of Emergency Medical Services
Scope of Practice - Procedures for EMS Personnel

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PROCEDURE	SKILL	PROCEDURE SUBTYPE	EMR	EMT	AEMT	I	P
Blood and Component Therapy Administration		Maintain				●	●
		Initiate					●
Diagnostic Procedures							
	Blood chemistry analysis			●	●	●	●
	Capnography			●	●	●	●
	Pulmonary function measurement				●	●	●
	Pulse Oximetry			●	●	●	●
	Ultrasonography						●
Genital/Urinary							
	Bladder catheterization						
	Foley catheter	Place bladder catheter					●
		Maintain bladder catheter		●	●	●	●
Head and Neck							
	ICP Monitor (maintain)						●
	Control of epistaxis		●	●	●	●	●
		Inserted epistaxis control devices			●	●	●
	Tooth replacement		●	●	●	●	●
Hemodynamic Techniques							
	Arterial catheter maintenance						●
	Central venous maintenance				●	●	●
	Access indwelling port					●	●
	Intraosseous access & infusion				●	●	●
	Peripheral venous access and maintenance				●	●	●
	Umbilical Catheter Insertion/Management						●
	Monitoring Existing IVs			●	●	●	●
	Mechanical IV Pumps				●	●	●
Hemodynamic Monitoring							
	ECG acquisition		●	●	●	●	●
	ECG Interpretation					●	●
	Invasive Hemodynamic Monitoring						●
	Vagal Maneuvers/Carotid Massage					●	●
Obstetrics							
	Delivery of newborn		●	●	●	●	●
Other Techniques							

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	Vital Signs		●	●	●	●	●
	Bleeding control		●	●	●	●	●
		Tourniquets	●	●	●	●	●
	Foreign body removal	Superificial without local anesthesia		●	●	●	●
		Imbedded with local anesthesia/exploration				●	●
	Incision/Drainage						●
	Intravenous therapy				●	●	●
	Medication administration			●	●	●	●
	Nasogastric tube			●	●	●	●
	Orogastric tube			●	●	●	●
	Pericardiocentesis						●
	Pleural decompression					●	●
	Patient restraint physical			●	●	●	●
	Patient restraint chemical					●	●
	Sexual assault victim management			●	●	●	●
	Trephination of nails						●
	Wound closure techniques					●	●
	Wound management		●	●	●	●	●
	Pressure Bag for High altitude						●
	Treat and Release			●	●	●	●
	Vagal Maneuvers/Carotid Massage					●	●
	Intranasal medication administration	Fixed/unit dose medications	●	●	●	●	●
		Dose calculation/measurement			●	●	●
Resuscitation							
	Cardiopulmonary resuscitation (CPR) (all ages)		●	●	●	●	●
	Cardiac pacing					●	●
	Defibrillation/Cardioversion	AED	●	●	●	●	●
	Post resuscitative care			●	●	●	●
Skeletal Procedures							
	Care of the amputated part		●	●	●	●	●
	Fracture/Dislocation immobilization techniques		●	●	●	●	●
	Fracture/Dislocation reduction techniques	Manipulation of angulated/pulseless extremities		●	●	●	●
		Joint reduction techniques		●	●	●	●
	Spine immobilization techniques		●	●	●	●	●
Thoracic							
	Thoracostomy (refer to "Other Techniques")						●
Body Substance Isolation / PPE			●	●	●	●	●
Lifting and moving techniques			●	●	●	●	●

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PROCEDURE	SKILL	PROCEDURE SUBTYPE	EMR	EMT	AEMT	I	P
Gastro-Intestinal Techniques							
	Management of non-displaced gastrostomy tube						●
Ophthalmological							
	Morgan Lenses			●	●	●	●
	Corneal Exam with fluorescein					●	●
	Ocular irrigation		●	●	●	●	●

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Virginia Office of Emergency Medical Services
Scope of Practice - Formulary for EMS Personnel

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CATEGORY		EMR	EMT	AEMT	I	P		
Analgesics								
	Acetaminophen		●	●	●	●		
	Nonsteroidal anti-inflammatory		●	●	●	●		
	Opiates and related narcotics			●	●	●		
	Dissociative analgesics							
	Ketamine 0.5 mg/kg or less IV/IN/IM				●	●	Added IM as a route of administration 10-4-18	
Anesthetics/Sedatives								
	Topical/Otic/Occular		●	●	●	●		
	Inhaled-self administered		●	●	●	●		
	Local (infiltration)			●	●	●		
	General - initiate					●		
	General - maintenance intubated patient				●	●	Added as a category and maintained at the I level, MDC 10-4-18	
	Sedation for the violent/aggressive patient				●	●	Added as a category and maintained at the I level, MDC 10-4-18	
	Antipsychotics				●	●		
	Benzodiazepines (for sedation)				●	●		
Anticonvulsants				●	●	●		
Glucose Altering Agents								
	Glucose Elevating Agents		●	●	●	●		
	Glucose Lowering Agents				●	●		
Antidotes								
	Anticholinergic Antagonists				●	●		
	Anticholenesterase Antagonists	●	●	●	●	●		
	Benzodiazepine Antagonists							
	Narcotic Antagonists	●	●	●	●	●		
	Nondepolarizing Muscle Relaxant Antagonist							
	Beta/Calcium Channel Blocker Antidote				●	●		
	Tricyclic Antidepressant Overdose				●	●		
	Cyanide Antidote				●	●		
	Cholinesterase Reactivator	●	●	●	●	●		
Antihistamines & Combinations			●	●	●	●		

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CATEGORY		EMR	EMT	AEMT	I	P		
Biologicals								
	Immune Serums				●	●		
	Antibiotics		●	●	●	●		
Blood/Blood products								
	Initiate					●		
	Maintain				●	●		
Blood Modifiers								
	Anticoagulants				●	●		
	Antiplatelet Agents		●	●	●	●		
	Hemostatic Agents		●	●	●	●		
	Thrombolytics					●		
	Anti-fibrinolytics (eg tranexamic acid)			●	●	●	Added at the AEMT level, MDC 10-4-18	
Cardiovascular Agents								
	Alpha Adrenergic Blockers				●	●		
	Adrenergic Stimulants				●	●		
	Antiarrhythmics				●	●		
	Beta Adrenergic Blockers				●	●		
	Calcium Channel Blockers				●	●		
	Diuretics				●	●		
	Inotropic Agents				●	●		
	Vasodilatory Agents		●	●	●	●		
	Vasopressors				●	●		
	Epinephrine for allergic reaction		●	●	●	●		
	Epinephrine administration systems for allergic reaction (See note below)		●	●	●	●	Approved by MDC 1-3-19	
Central Nervous System	Antipsychotic				●	●		
							Sedatives - Benzodiazepines removed from this section, MDC 10-4-18	

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Scope of Practice - Formulary for EMS Personnel

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CATEGORY		EMR	EMT	AEMT	I	P		
Dietary Supplements/Electrolyte	Vitamins							
	Minerals - start at a health care facility	See section: Intravenous Fluids						
	Salts - start at a health care facility							
	Electrolytes Solutions - started at a health care facility							
	Hypertonic Saline				●	●		
Gas								
	Oxygen	●	●	●	●	●		
	Heliox				●	●		
Gastrointestinal								
	Antacids							
	OTC			●	●	●		
	Antidiarrheals		●	●	●	●		
	Antiemetics		●	●	●	●		
	EMT SL/PO route only							
	H2 Blockers		●	●	●	●		
Hormones	Corticosteroids, Mineralocorticoids			●	●	●		
	Other Hormones							
	pitocin, octreotide, prostaglandins					●		
Intravenous Fluids	isotonic		●	●	●	●	EMT may transport patient with IV fluids not requiring titration or adjustment, and	
* See note below)	hypotonic		●	●	●	●		
	hypertonic				●	●		
	M = Maintenance I = Initiate							
	Crystalloid, +/- Dextrose/Lactate		M	I/M	I/M	I/M		
	with Multi=vitamins		M	M	M	M		
	with Thiamine		M	M	M	M		
Neuromuscular Blockers						●		
Respiratory	Anticholinergics		●	●	●	●		
	Sympathomimetics							
	Beta agonists		●	●	●	●		
	Epinephrine (nebulized)				●	●		
Dosage and Concentration Calculation				●	●	●		

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CATEGORY		EMR	EMT	AEMT	I	P		
M = Maintenance								
I = Initiate								
	Note: EMT's may administer medications within their scope of practice in addition to assistance in administration of those medications. EMT's may access a drug kit to access those medications.							

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Appendix

F

Virginia Department of Health, Office of EMS

Mobile Integrated HealthCare /Community Paramedicine (MIH-CP) in Virginia

October 1, 2019

Background:

Mobile Integrated Healthcare-Community Paramedicine (MIH-CP) is a relatively new and evolving healthcare model. It allows paramedics and emergency medical technicians (EMTs) to operate in expanded roles by assisting with public health, primary healthcare and preventive services to underserved populations in the community. The goal is to improve access to care, community wellness, and quality of life, and avoid duplicating existing services.

Some rural patients lack access to primary care and use 911 and emergency medical services (EMS) to receive healthcare in non-emergency situations. This can create a burden for EMS personnel and health systems in rural areas. Community paramedics can work in a public health and primary care role to address the needs of rural residents in a more efficient and proactive way. In urban settings, MIH-CP can improve access to care and/or navigation to proper care, as well as decreased call volume of patients who call 911 at a significantly high amount.

The term mobile integrated healthcare (MIH) is often used interchangeably with community paramedicine, particularly outside of the EMS community. However, MIH can be broader, including healthcare services provided outside of a healthcare facility by any type of health professional, such as community health workers (CHWs). To be inclusive, some organizations (including OEMS) use the term mobile integrated healthcare and community paramedicine (MIH-CP).

MIH-CP is a means for EMS providers to monitor patients post discharge (especially the first 24-36 hours), treats minor issues that may not require a visit/readmission, and/or transport to an alternate destination. It also includes care patients with complex needs in the community, patients with limited access, and other unique target populations (opiates, homeless, uninsured).

It has been generally accepted that there are portions of not only Virginia, but across the country, where there are identified underserved populations and gaps in access to healthcare. EMS strives to be an active partner in helping to bridge those gaps in the areas of, and not including: wellness checks, mental health evaluations, opioid screenings, alternate destination considerations, referral to other healthcare providers, and point of dispensing (POD) immunization clinics.

In 2019, the Center for Medicare and Medicaid Services (CMS) has released information related to a new program, known as the Emergency Triage, Treat, and Transport (ET3) model. ET3 is a voluntary, five-year payment model that will provide greater flexibility to ambulance care teams to address emergency health care needs of Medicare beneficiaries following a 911 call. Under the ET3 model, the Centers for Medicare & Medicaid Services (CMS) will pay participating ambulance suppliers and providers to 1) transport an individual to a hospital emergency department (ED) or other destination covered under the regulations, 2) transport to an alternative destination (such as a primary care doctor's office or an urgent care clinic), or 3) provide treatment in place with a qualified health care practitioner, either on the scene or connected using telehealth. The model will allow beneficiaries to access the most appropriate emergency services at the right time and place. The model will also encourage local governments, their designees, or other entities that operate or have authority over one or more 911 dispatches to promote successful model implementation by establishing a medical triage line for low-acuity 911 calls. As a result, the ET3 model aims to improve quality

and lower costs by reducing avoidable transports to the ED and unnecessary hospitalizations following those transports.

In 2015, OEMS convened a workgroup to look at the concept of Mobile Integrated Healthcare/Community Paramedicine in the EMS system in Virginia. The workgroup was made up of entities with a stake in this process. At the time, the workgroup concluded that the Office of EMS, in cooperation with the Office of Licensure and Certification (OLC) set forth a process to inform EMS agencies that have an interest in providing MIHP/CP what they must do in order to comply with the existing laws and rules of the Commonwealth. Agencies had to go through the process of recognition as a home health agency with OLC in order to implement an MIH-CP program.

The MIH/CP workgroup that was created in 2015 reconvened on September 19, 2018, with Dr. Allen Yee again serving as chair. The workgroup met on November 7, 2018, and January 29, March 1, April 24, May 30, June 25, July 23, August 27, and October 23, 2019.

The mission of the MIH/CP workgroup is as follows:

The Mobile Integrated Healthcare – Community Paramedicine (MIH-CP) Workgroup (a work group of the State Medical Direction Committee) provides expert guidance to the OEMS Advisory Board and the Virginia Healthcare System regarding appropriate standards and recommendations to promote a high quality, data driven, and safe Mobile Integrated Healthcare – Community Paramedicine system operations for the potential gaps in healthcare in Virginia. The workgroup aims to promote, advocate, and educate stakeholders about MIH and CP as a resource to collaborate, integrate, and enhance patient and family centered care.

Previous meeting minutes can be found via the link below:

http://www.vdh.virginia.gov/emergency-medical-services/community-paramedicine-mobile-integrated-healthcare/

In addition to the activities of the MIH-CP workgroup, a bill (Senate Bill 1226) was introduced into the 2019 Virginia General Assembly session regarding Community Paramedicine.

A summary of the bill as introduced *"requires the State Board of Health to adopt regulations governing the practice of community paramedics. The bill requires an applicant for licensure as a community paramedic to submit evidence that the applicant (i) is currently certified as an emergency medical services provider and has been certified for at least three years, (ii) has successfully completed a community paramedic training program that is approved by the Board or accredited by a Board-approved national accreditation organization and that includes clinical experience provided under the supervision of a physician or EMS agency, and (iii) has obtained Community Paramedic Certification from the International Board of Specialty Certification. The bill requires a community paramedic to practice in accordance with protocols and supervisory standards established by an operational medical director and to provide services only as directed by a patient care plan developed by the patient's physician, nurse practitioner, or physician assistant and approved by the community paramedic's supervising operational medical director.*

The bill exempts a community paramedic providing services in accordance with the provisions of the bill from licensure as a home health organization. The bill requires the State Board of Medical Assistance Services to include in the state plan for medical assistance services a provision for the payment of medical assistance for home health services provided by a certified community paramedic exempt from licensure as a home health organization."

The full text of SB 1226 can be found via the link below.

https://lis.virginia.gov/cgi-bin/legp604.exe?191+ful+SB1226+pdf

The Senate Committee on Education and Health unanimously voted to pass by SB 1226 for the 2019 session.

Based on the discussions and deliberations of the workgroup, the main items addressed are guidelines for implementation of an MIH-CP program, the protocols that the program operates under, training for the providers functioning in the MIH-CP program, and the funding/finances for program implementation and sustainability.

Guidelines for MIH-CP Program Implementation

The workgroup acknowledges the concept that the needs of one EMS system may vary significantly from those of another EMS system. While the workgroup does not endorse any particular needs assessment tool, it does acknowledge the existence of several such tools, and the Virginia OEMS aims to build a "virtual resource center" where interested parties can find many different assessment tools, and determine which is best suited for their agency and their respective EMS system.

The MIH-CP workgroup has developed guidelines for any EMS agencies in Virginia wishing to implement an MIH-CP program, versus the development and promulgation of MIH-CP regulations. This is based on the time required for regulations to be promulgated and well as changes that may need to be made to those regulations after they've been promulgated. Those agencies, prior to MIH-CP program administration, must be able to demonstrate the ability to respond to all emergency calls for that agency's primary response area.

Guidelines for EMS Agency
Mobile Integrated Healthcare - Community Paramedicine (MIH-CP)
Program Implementation

Mobile Integrated Healthcare - Community Paramedicine (MIH-CP) Definitions

- Mobile Integrated Healthcare (MIH) - the provision of healthcare using patient-centered, mobile resources in the out-of-hospital environment. It may include, but is not limited to, services such as providing telephone advice to 9-1-1 callers instead of resource dispatch; providing community paramedicine care, chronic disease management, preventive care or post-discharge follow-up visits; or transport or referral to a broad spectrum of appropriate care, not limited to hospital emergency departments.
- Community Paramedicine - allows paramedics and emergency medical technicians (EMTs) to operate in expanded roles by assisting with public health and primary healthcare and preventive services to underserved populations in the community. The goal is to improve access to care and avoid duplicating existing services.
- Additional pertinent definitions can be found in the Virginia EMS Regulations
  - https://law.lis.virginia.gov/admincode/title12/agency5/chapter31/section10/

MIH-CP Agency licensure.

- Mobile Integrated Healthcare Community Paramedicine (MIH-CP) licensed agencies shall comply with the applicable regulations, the applicable regulations of other state agencies, the Code of Virginia, and the United States Code.
- MIH-CP agencies shall hold EMS agency licensure with the Virginia Office of EMS
- MIH-CP licensed agencies shall not be categorized or designated as home care agencies.
- MIH-CP endorsements may not be construed to authorize any agency to operate any EMS vehicle without a franchise or permit in any county or municipality, which has enacted an ordinance to do so.

MIH-CP Administration.

- Agencies that implement an MIH-CP program shall have clinical documentation program including:
  - Patient intake/admission to program;
  - Patient encounters
  - Formal discharge of a patient from and/or completion of a program.
- MIH-CP licensed agencies shall have a policy to address interdisciplinary and interagency collaboration and information sharing.
- MIH-CP licensed agencies shall have an endorsed EMS physician OMD.

MIH-CP agency personnel classifications.

- An MIH-CP agency may include the following personnel.
  - Physician
  - Nurse Practitioner
  - Physician Assistant
  - Registered Nurse

- Paramedic
- Intermediate
- AEMT
- EMT
- Specialty providers (*e.g. social services, mental health*).

Guidelines for EMS Agency MIH-CP Program Implementation (Cont.)

MIH-CP Program Training.
The MIH-CP licensed agency shall have a planned and structured educational program, approved by the agency OMD that personnel must successfully complete.

Minimum initial training for MIH-CP personnel and specialty providers:

- Didactic component of education:
- Clinical component of initial education:
  - Medication and equipment that supports the MIH-CP mission and scope of care of the service;
- Annual continuing education requirements:
  - Infection Control;
  - Hazardous materials recognition and response;
  - Scene safety;
  - Public health; and
  - Medication and equipment that supports the MIH-CP mission and scope of care of the service;

MIH-CP Program Equipment.

- Vehicle equipment.
  - Vehicles not already licensed as an ALS or BLS vehicle shall have medication and equipment that supports the MIH-CP mission and scope of care of the service;
- Vehicle markings:
  - Vehicles not already licensed as an ALS or BLS vehicle shall have
    - Name of agency on both sides
    - "MIH", "CP" or other designation as approved by OEMS on both sides.
- Vehicle communications.
  - Vehicles not already licensed as an ALS or BLS vehicle shall have communications equipment that supports the MIH-CP mission and scope of care of the service.

MIH-CP Program Protocols

It is the opinion of the MIH-CP workgroup that development of MIH-CP program protocols for the treatment of patients is the ultimate responsibility of the agency Operational Medical Director. Protocols shall not exceed the scope of practice for each certification level of the agency's providers.

MIH-CP Program Training

Given the fact that the National Registry of Emergency Medical Technicians (NREMT), the National Association of State EMS Officials (NASEMSO), the National Association of EMS Physicians (NAEMSP) and other related stakeholder groups have not taken an official position and/or endorsement of an MIH-CP specific training program or examination, the Virginia Office of EMS has elected to not take an official position/endorsement as well. Training of providers for an agency specific MIH-CP orientation program or other related training shall be done with the involvement and approval of the program operational medical director. In addition, the Virginia Office of EMS is committed to including MIH-CP related content to each Virginia EMS Symposium in the future.

MIH-CP Program Funding

The MIH-CP workgroup acknowledges the many challenges that exist for an EMS agency to implement and sustain and MIH-CP program from a financial perspective. It is the hope of the workgroup that the EMS community continue to work with insurance payors and health systems to determine ways in which cost savings can be demonstrated from the use of MIH-CP programs, and the CMS continue to explore avenues (such as ET3) to promote the financial success, viability, and sustainability of MIH-CP programs.

Appendix G

NOTICE OF INTENT TO PROVIDE MIH/CP SERVICES

This application is intended to serve as notice to the Virginia Office of Emergency Medical Services (OEMS), that an EMS agency, currently licensed by OEMS, intends to implement a Mobile Integrated Healthcare/Community Paramedicine (MIH/CP) program in their primary response area.

This Notice of Intent shall contain the following information*:

Section I: General Agency Information
Section II: Type of/Justification For MIH/CP Program Implementation
Section III: MIH/CP Program Description
Section IV: Patient Interaction Plan
Section V: Staffing Plan
Section VI: Training Plan
Section VII: Medical Direction/Protocol Development/Quality Improvement
Section VIII: Data Collection
Section IX: Letters of Support from Collaborating Entities

***Applicant agency shall provide specific documents as attachments to the application as appropriate.**

Section I: General Agency Information:

Date of Notice of Intent Completion: _____

EMS Agency Name: _____

EMS Agency OEMS Licensure Number: _____

EMS Agency Physical Address: _____

Additional Agency Station/Base Locations (If Applicable) _____

_____

_____

Does the agency plan to market itself as an MIH/CP provider? Yes ____ No ____

Does the agency plan affix MIH/CP specific lettering or decals to agency vehicles? Yes ____ No ____

Agency Representative Completing Survey: _____

E-mail address: _____

Contact Telephone Number: _____

Name of Agency leader/Chief Officer: _____

Signature of Agency leader/Chief Officer: _____

Name of Operational Medical Director (OMD): _____

Signature of Operational Medical Director: _____

Section II: Type of/Justification for MIH/CP Program:

Please indicate below what type of program the agency intends to provide (MIH or CP), as well as the justification for the program, including any assessment tools used:

Section III: MIH/CP Program Description:

Please provide a description below of what the intended MIH/CP program will encompass. Please be a specific as possible:

Section IV: Patient Interaction Plan:

Please provide a description below of the intended/target patient population, including intake and discharge from the program. Please be a specific as possible:

Section V: Staffing Plan:

Please provide a description below of the types of providers that the agency intends to staff the MIH/CP program with. Please be a specific as possible:

Section VI: Training Plan:

Please provide a description below of any MIH/CP specific training that the agency intends to include in their program. Please be a specific as possible:

Section VII: Medical Direction/Protocol Development/Quality Improvement Plan:

Please provide a description below of the involvement of the OMD in the MIH/CP program, any MIH/CP specific protocols that the agency intends to utilize, and the quality improvement program the agency intends to utilize to measure the effacy of the program. Please be a specific as possible:

Section VIII: Data Collection:

Please provide a description below of the method the agency intends to utilize to collect and measure data pertinent to the program. Please be a specific as possible:

Section IX: Letters of Support From Collaborating Agencies:

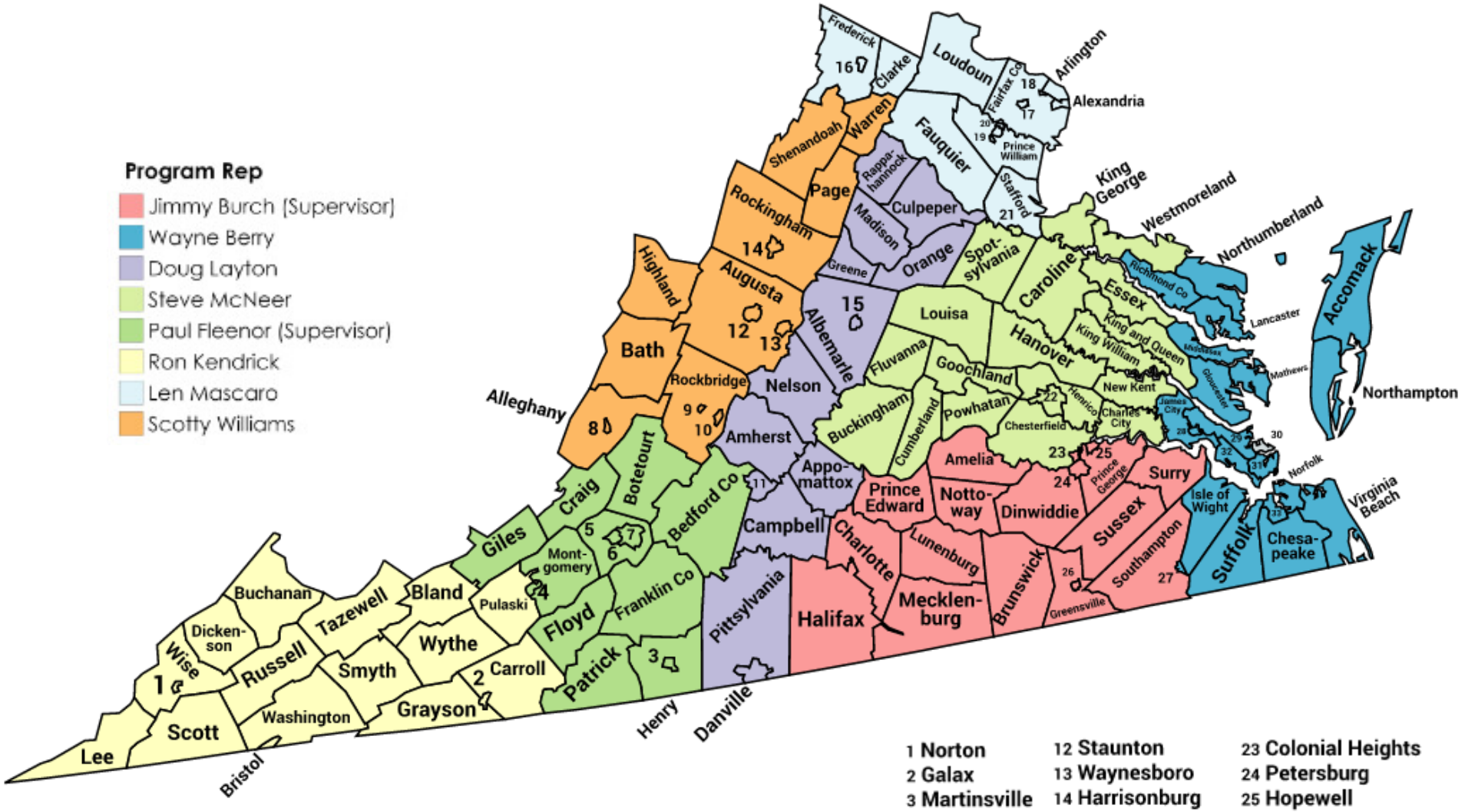
Please utilize this section to identify and attach letters of support from collaborating entities who intend to provide assistance to the applicant in the implementation and/or sustainability of the program. Letters shall be on entity letterhead, and specific in the description of the type of assistance the entity intends to provide to the applicant's MIH/CP program (financial, staffing, vehicles, equipment, etc.):

Upon completion, the application and all related attachments and materials are to be submitted to:

Tim Perkins, Manager
Division of Community Health and Technical Resources
Virginia Department of Health
Office of Emergency Medical Services
tim.perkins@vdh.virginia.gov

Appendix

H



1 Norton
2 Galax
3 Martinsville
4 Radford
5 Roanoke Co
6 Salem
7 Roanoke
8 Covington
9 Lexington
10 Buena Vista
11 Lynchburg
12 Staunton
13 Waynesboro
14 Harrisonburg
15 Charlottesville
16 Winchester
17 Fairfax
18 Falls Church
19 Manassas
20 Manassas Park
21 Fredericksburg
22 Richmond
23 Colonial Heights
24 Petersburg
25 Hopewell
26 Emporia
27 Franklin
28 Williamsburg
29 York
30 Poquoson
31 Hampton
32 Newport News
33 Portsmouth

Program Representatives

Jimmy Burch Supervisor	Doug Layton	Steve McNeer	Wayne Berry		Paul Fleenor Supervisor	Ron Kendrick	Scotty Williams	Len Mascaro
Counties:	**Counties:**	**Counties:**	**Counties:**		**Counties:**	**Counties:**	**Counties:**	**Counties:**
Amelia	Albemarle	Buckingham	Accomack		Botetourt	Bland	Alleghany	Arlington
Brunswick	Amherst	Caroline	Gloucester		Craig	Buchanan	Augusta	Clarke
Charlotte	Appomattox	Charles City	Isle of Wight		Floyd	Carroll	Bath	Fairfax Co
Dinwiddie	Bedford	Chesterfield	James City		Franklin Co	Dickenson	Highland	Fauquier
Greensville	Campbell	Cumberland	Lancaster		Giles	Grayson	Page	Frederick
Halifax	Culpeper	Essex	Mathews		Henry	Lee	Rockbridge	Loudoun
Lunenburg	Greene	Fluvanna	Middlesex		Montgomery	Pulaski	Rockingham	Prince William
Mecklenburg	Madison	Goochland	Northampton		Patrick	Russell	Shenandoah	Stafford
Nottoway	Nelson	Hanover	Northumberland		Roanoke Co	Scott	Warren	
Prince Edward	Orange	Henrico	Richmond Co			Smyth		**Cities:**
Prince George	Pittsylvania	King and Queen	York		**Cities:**	Tazewell	**Cities:**	Alexandria
Southampton	Rappahannock	King George			Martinsville	Washington	Buena Vista	Fairfax
Surry		King William	**Cities:**		Radford	Wise	Covington	Falls Church
Sussex	**Cities:**	Louisa	Chesapeake		Roanoke	Wythe	Harrisonburg	Manassas
	Charlottesville	New Kent	Franklin		Salem		Lexington	Manassas Park
Cities:	Danville	Powhatan	Hampton			**Cities:**	Staunton	Winchester
Colonial Heights	Lynchburg	Spotsylvania	Newport News			Bristol	Waynesboro	
Emporia		Westmoreland	Norfolk			Galax		
Hopewell			Poquoson			Norton		
Petersburg		**Cities:**	Portsmouth					
		Fredericksburg	Suffolk					
		Richmond	Virginia Beach					
			Williamsburg					